PATIENT HEALTH QUESTIONNAIRE

Name: ________________________________ Date: ________________

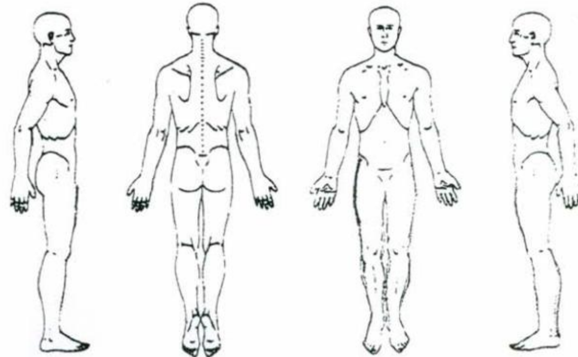
HISTORY OF PRESENT COMPLAINT

What is your chief complaint? ____

When did your symptoms start? ____________ Describe how they began: ____________________________

Location: ____________________________
Where is the pain/problem?

Show on the diagram where you experience your symptoms



Quality: How does the pain feel? (circle all that apply):
Sharp, Shooting, Dull Ache, Burning, Numbness, Tingling

Severity: How severe is pain/problem on a scale of 0-10
(10 being most severe)
0 1 2 3 4 5 6 7 8 9 10

Timing: ____________________________
Time of day you notice pain/problem

How often do you experience your symptoms?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Does this pain wake you up at night? ☐ Yes ☐ No

Other Symptoms: ____
What other problems have you been experiencing?

How do your symptoms affect your ability to perform daily activities? (please circle one)

No complaints	Mild, forgotten with activity	Moderate, interferes with activity	Limiting, prevents full activity	Intense, preoccupied with seeking relief	Severe, no activity possible

What makes your symptoms worse? ____________________ What makes your symptoms better? ____________________

Who else have you seen for your symptoms? ________________________________
When and what treatment was given? ________________________________
Did you have any specific tests performed by other practitioner? ________________________________
(X-Rays, MRI, CT Scan, Blood Tests, etc…)

Have you had similar symptoms in the past? ☐ Yes ☐ No
If yes, please describe: ____________________ How were symptoms relieved? ____________________

Have you ever been to a chiropractor before? ☐ Yes ☐ No Name of Chiropractor: ____________________
Date of last treatment? ____________ Did they take x-rays? ☐ Yes ☐ No

What did you like or dislike about treatment?

List all prescription and over-the-counter medications you are taking:	List all nutritional/herbal supplements you are taking:	List all hospitalizations/surgeries you have had:

Have you been in an auto accident? ☐ Past Year ☐ Past Five Years ☐ Over Five Years
Describe: ____

REVIEW OF SYSTEMS

Past	Present	
		EENT
☐	☐	Eye Disease/Injury
☐	☐	Blurred or Double Vision
☐	☐	Hearing Loss or Ringing
☐	☐	Earaches/Infections
☐	☐	Chronic Sinus Problems
☐	☐	Chronic Sore Throats
☐	☐	Nose Bleeds
		CARDIOVASCULAR
☐	☐	Chest Pain
☐	☐	Heart Palpitations
☐	☐	Shortness of Breath
☐	☐	High Blood Pressure
☐	☐	Stroke
☐	☐	Varicose Veins
		RESPIRATORY
☐	☐	Chronic Cough
☐	☐	Coughing Up Blood
☐	☐	Wheezing
		GASTROINTESTINAL
☐	☐	Change in Appetite
☐	☐	Nausea or Vomiting
☐	☐	Heartburn
☐	☐	Ulcers
☐	☐	Change in Bowel Mvts.
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Black/Bloody Stools
☐	☐	Abdominal Pain/Cramps
☐	☐	Liver Problems
☐	☐	Gall Bladder Problems
☐	☐	Weight Concerns
☐	☐	Gas/Bloating after Meals
☐	☐	Inflammatory Bowel Disease

Past	Present	
		GENITOURINARY
☐	☐	Frequent Urination
☐	☐	Painful/Burning Urination
☐	☐	Recurrent Bladder/Kidney Infections
☐	☐	Yeast Infections
☐	☐	Bloody/Discolored Urine
☐	☐	Incontinence
☐	☐	Kidney Stones
☐	☐	Sexual Difficulty
		MALES
☐	☐	Testicular Problems/Pain
☐	☐	Prostate Problems
		FEMALES
☐	☐	Painful Periods
☐	☐	Irregular Periods
☐	☐	Fertility Issues
☐	☐	Abnormal PAP
		MUSCULOSKELETAL
☐	☐	Headaches
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Elbow, Wrist, Hand Pain
☐	☐	Carpal Tunnel Syndrome
☐	☐	Hip Problems
☐	☐	Knee Pain/Problems
☐	☐	Ankle/Foot Pain
☐	☐	Joint Stiffness
☐	☐	Joint Swelling
☐	☐	Muscle Pain or Cramps
☐	☐	Muscle Weakness
☐	☐	Difficulty Walking
☐	☐	Jaw Pain/Clicking Jaw
☐	☐	Loss of Muscle Control

Past	Present	
		NEUROLOGICAL
☐	☐	Light Headed or Dizzy
☐	☐	Fainting
☐	☐	Confusion
☐	☐	Numbness/Tingling
☐	☐	Convulsions/Seizures
☐	☐	Tremors
☐	☐	Paralysis
☐	☐	Head Injury
		PSYCHIATRIC
☐	☐	Nervousness/Anxiety
☐	☐	Depression
☐	☐	Mental Illness
		ENDOCRINE
☐	☐	Thyroid Problems
☐	☐	Other Glandular Problems
		Describe: ____________
☐	☐	Hormonal Problems
☐	☐	Excessive Thirst/Urination
☐	☐	Excessive Fatigue
☐	☐	Heat/Cold Intolerances
☐	☐	Sudden Weight Gain/Loss
☐	☐	Skin Changes
		HEMATOLOGICIC
☐	☐	Hemophilia
☐	☐	Blood Clotting Problems
☐	☐	Blood Clots
☐	☐	Bruise Easily
☐	☐	Phlebitis
		ALLERGIC/IMMUNOLOGIC
☐	☐	Seasonal/Environmental
☐	☐	Food Sensitivities
☐	☐	Severe Allergic Reaction
☐	☐	Auto Immune Disorder
☐	☐	Immune Deficiency
☐	☐	Recurrent Infections

Check any of the following conditions you have or have had:

- ☐ Alcohol/Drug Dependence
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Congenital Birth Defect
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: ____________

FAMILY HEALTH INFORMATION – please indicate if any family members have or had any diseases. Many health problems are hereditary, thus information about your family members will give us a better picture of your total health.

Father: ______________________ Mother: ______________________

Siblings: ______________________ Children: ______________________

Maternal Grandparents: ______________________ Paternal Grandparents: ______________________

PERSONAL LIFESTYLE HABITS –	Heavy	Moderate	Light	None
Coffee	☐	☐	☐	☐
Alcohol Consumption	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Sleep (hours/night): ____________

Do you feel you eat healthy? ☐ Yes ☐ No

Do you think you need vitamins? ☐ Yes ☐ No

I hereby acknowledge the above information is true and accurate. I hereby authorize the Doctor to treat my condition as he or she deems appropriate.

______________________________ ______________________________

Signature of Patient or Responsible Party **Date** **Relationship to Patient**