White CHIROPRACTIC

PATIENT HEALTH QUESTIONNAIRE

Name: ____ Date: ______________

HISTORY OF PRESENT COMPLAINT

What is your chief complaint? ____

When did your symptoms start? _________________________ Describe how they began: ___________________________

Where is the pain/problem? ____

Circle on the diagram where you experience your symptoms

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

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

Time of day you notice the pain/problem:
☐ Morning ☐ Afternoon ☐ Evening

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

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

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: ____
Other significant injuries: ____

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
☐	☐	Hormonal Problems
☐	☐	Excessive Thirst/Urination
☐	☐	Excessive Fatigue
☐	☐	Heat/Cold Intolerances
☐	☐	Sudden Weight Gain/Loss
☐	☐	Skin Changes
		Hematologic
☐	☐	Hemophilia
☐	☐	Blood Clotting Problems
☐	☐	Blood Clots
☐	☐	Bruise Easily
☐	☐	Phlebitis
		Allergic/Immunologic
☐	☐	Season/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
Caffeine	☐	☐	☐	☐
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**