

Patient Health Questionnaire

Patient Name: _____

Date: ____/____/____

Please check either the past or present column for each symptom/condition you have or have had. If you haven't experienced the symptom/condition then leave blank. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE AND IT'S OUTCOME.**

Past	Present	Symptom/Condition	Past	Present	Symptom/Condition
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Numbness (Where: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Angina / Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Allergy (To what: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Hand (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Arm / Wrist (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Back (Lumbar)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Bladder / Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Mid (thoracic) Back / Between Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	Bursitis (Where: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Neck (cervical)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Shoulder (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Depression / Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg/Thigh or Hip (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disorders (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problem
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Headache (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (Date: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (Date: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C)	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tumor (Type/Where: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular In-coordination	Women Only: 1 st day of last menstrual period _____		

PAST HEALTH HISTORY:

- | | |
|--|---|
| 1) Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No
When? _____
For what? _____ | 4) Have you had any x-rays/imaging studies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Of what? _____
Was anything identified? <input type="checkbox"/> Yes <input type="checkbox"/> No
What was identified? _____ |
| 2) Have you had any other Injuries/Traumas/Accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No
When? _____
What happened? _____
Any residual effects/problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | 5) Have you ever seen a Chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No
When? _____ Did it help? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have any problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
What problems? _____ |
| 3) Do you take any Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____
For what? _____ | 6) When was your last physical exam? _____
What were the results? _____ |

FAMILY HISTORY:

- 1) Does any of your family members have or have had any of the following health conditions? (Check all that apply):
 Arthritis Cancer Diabetes Heart Problems High Blood Pressure Lung Problems Other: _____
- 2) Have any of your immediate family members passed away due to a health condition listed above? Yes No
Whom? _____ Which health condition? _____

PERSONAL HISTORY:

- | | |
|---|---|
| 1) What is the highest level of education you have received? <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Post Graduate Studies | 7) How much of the following do you use daily?:
Water <input type="checkbox"/> <3 cups <input type="checkbox"/> 3-8 cups <input type="checkbox"/> 8-12 cups <input type="checkbox"/> >12 cups
Coffee <input type="checkbox"/> None <input type="checkbox"/> 1-3 cups <input type="checkbox"/> 3-5 cups <input type="checkbox"/> >5 cups
Soft Drinks <input type="checkbox"/> None <input type="checkbox"/> 1-3cups/cans <input type="checkbox"/> >3 cups/cans
Alcohol <input type="checkbox"/> None <input type="checkbox"/> 1-3 drinks/cans <input type="checkbox"/> >3 drinks/cans
Tobacco <input type="checkbox"/> None <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe
How much? _____
Marijuana <input type="checkbox"/> None <input type="checkbox"/> 1-3x/day <input type="checkbox"/> 3-5x/day <input type="checkbox"/> >5x/day
Do you have your card? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2) Does your job primarily require:
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Don't work | |
| 3) Describe your Stress level: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> High
Can you handle your stress/have an outlet? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 4) Do you exercise:
<input type="checkbox"/> None <input type="checkbox"/> Some (1-2 x/wk) <input type="checkbox"/> Moderate (3-4 x/wk) <input type="checkbox"/> Lots (5-7 x/wk)
What do you do? <input type="checkbox"/> Walk/hike <input type="checkbox"/> Bike <input type="checkbox"/> Swim <input type="checkbox"/> Weights <input type="checkbox"/> Other | |
| 5) What do you do for fun/hobbies? _____ | |
| 6) How well do you sleep at night? <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent
How long do you sleep at night? <input type="checkbox"/> 0-4hrs <input type="checkbox"/> 4-6hrs <input type="checkbox"/> 6-8hrs <input type="checkbox"/> >8hrs | |

I certify that the information I have supplied is true and accurate to the best of my knowledge.

Patient Signature: _____

Date: ____/____/____