Patient Health Questionnaire

Patient Name____________________ **Date**__________

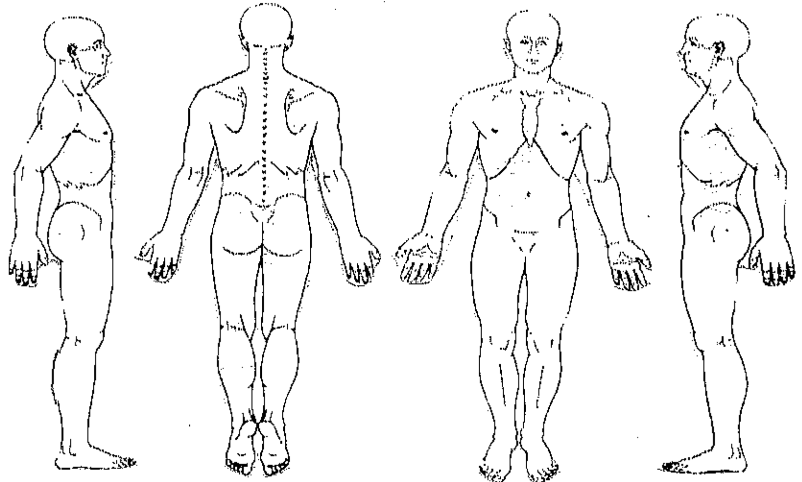
1. Describe your symptoms ____________________

a. When did your symptoms start? ____________________
b. How did your symptoms begin? ____________________

2. How often do you experience your symptoms?

1. constantly (76- 100% of the day)
2. frequently (51-75% of the day)
3. Occasionally (25-50% of the day)
4. Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

1. Sharp
2. Dull ache
3. Numb
4. Shooting
5. Burning
6. Tingling

4. How are your symptoms changing?

1. Getting better
2. Not changing
3. Getting worse

5. During the past 4 weeks:

(0=none 10 =Unbearable)

a. Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside and housework)?
1= not at all 2= A little bit 3= Moderately 4= Quite a bit 5= extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities:
(such as visiting friends, relatives, etc.)
1=All of the time 2= Most of the time 3= Some of the time 4= A little of the time 5= None of the time

7. In general would you say your overall health right now is…
1=Excellent 2=Very Good 3=Good 4=Fair 5= Poor

8. Who have you seen for your symptoms? 1=no one 2=Chiropractor 3= Medical Doctor 4=Physical Therapist 5= Other

a. What treatment did you receive and when? ____________________

b. What tests have you had for your symptoms When and where were they performed?
X-rays date: ________ CT Scan date: ________
MRI date: ________ Other date: ________

9. Have you had similar symptoms in the past? Yes No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
1= This office 2= another Chiropractor 3=Medical Doctor 4=Physical Therapist 5=Other

10. What is your occupation?
Status: Full Time
Part Time

1=Professional/Executive
2=White Collar/Secretarial
3=Tradesperson
4=Laborer
5=Homemaker
6=FT Student
7=Retired
8=Other

Patient Signature____________________ **Date**__________

Full Name____Date____________

Nickname__________________________Social Security Number____________________

Address___________________________City_________________Zip______________

Phone______________Cell Phone_________________Age_______Date of Birth____________

Marital Status_____________Spouse Name__________________# of Children______________

Your Employer______________How Long_____Position__________Work Phone___________

Spouse Employer_______________________________________Work Phone____________

In Case of Emergency: Nearest Relative_________________________Phone______________

Email Address_______________________________________(We do not share email addresses)

Who is your medical doctor?____

Do you want us to send your medical doctor a report of our findings?_________________________

How did you hear about our office?____

How will you pay today? ___Cash ____Check ____Visa/MC ____Debit Card ____Care Credit ____Discover

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What makes your condition better?____

What makes your condition worse?____

List your medicines____

List your vitamins/nutrients____

List any broken bones you have had____

List any surgery you have had____

Check all that apply: _____alcohol _____smoker _____nonsmoker _____caffeine _____blood thinners

Check if you have had: ___heart attack ___stroke ___cancer, if yes where______________________

Do you think you eat enough fresh fruits and vegetables?____________________________

Do you think you drink enough water?____

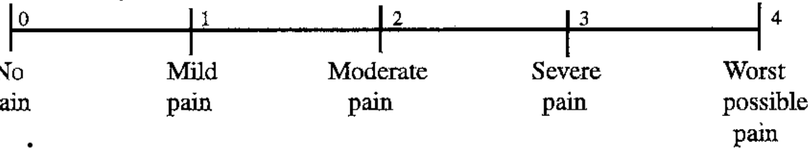
Is there anything else about your health the doctor needs to know?________________________

Functional Rating Index

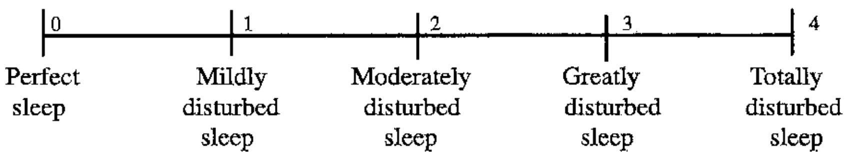
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

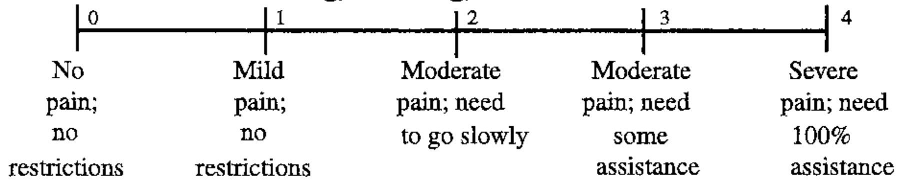
1. Pain Intensity



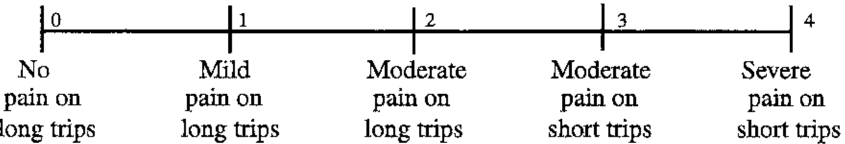
2. Sleeping



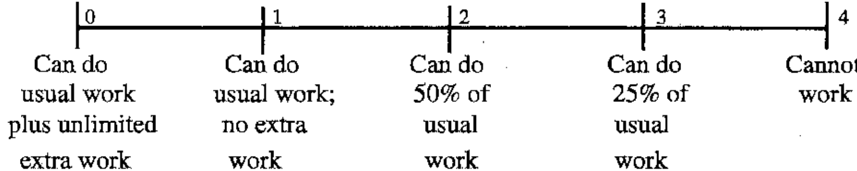
3. Personal Care (washing, dressing, etc.)



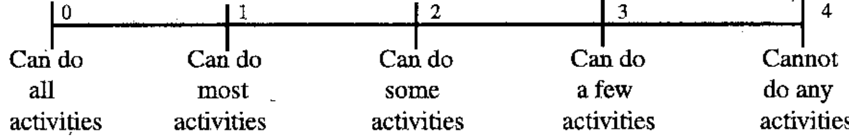
4. Travel (driving, etc.)



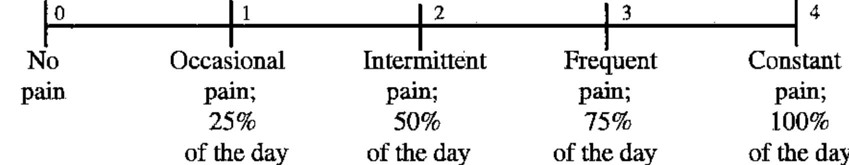
5. Work



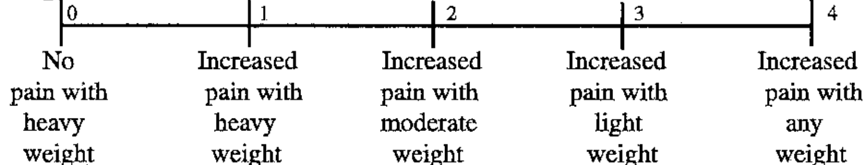
6. Recreation



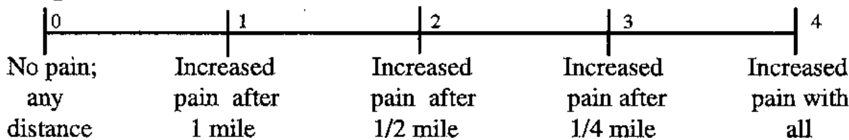
7. Frequency of pain



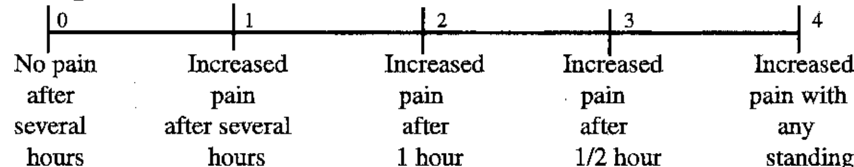
8. Lifting



9. Walking



10. Standing



Name ______________________ **ID#/SS#** ______________ **Plan ID** ________ **Total Score** ________

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______________________ ______________

Signature **Date**

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