Patient Health Questionnaire

Patient Name_____ **Date**_____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

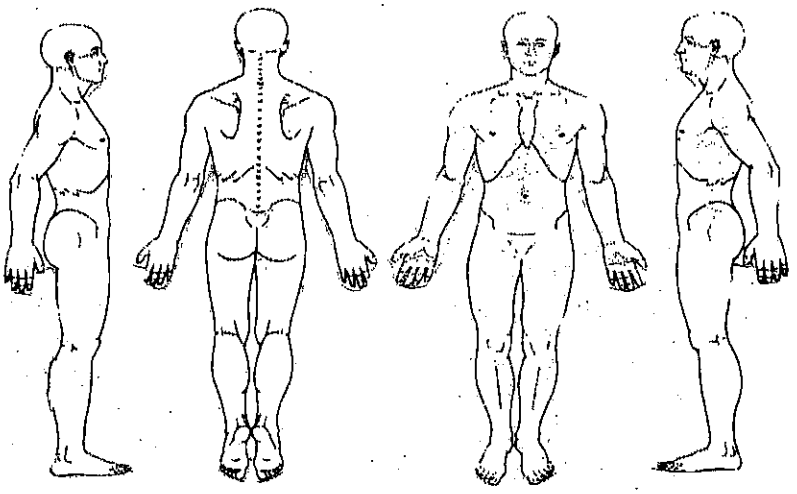
b. How did your symptoms begin? _____

_____

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**_____

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 _____

What do you hope to accomplish with your treatment here? _____

_____

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

_____

****

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? _____

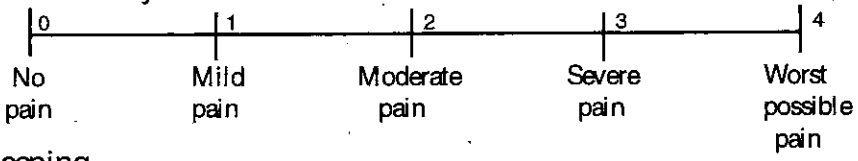
How will you pay today? ___Cash ___Check ___Visa/MC ___Debit ___Care Credit

Functional Rating Index

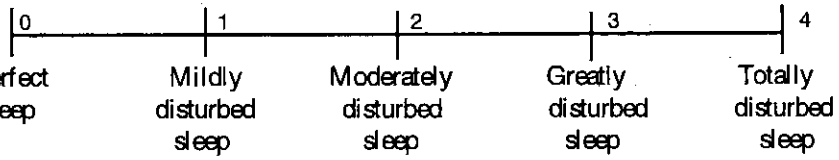
For use with Neck and/or Back Problems only.

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.

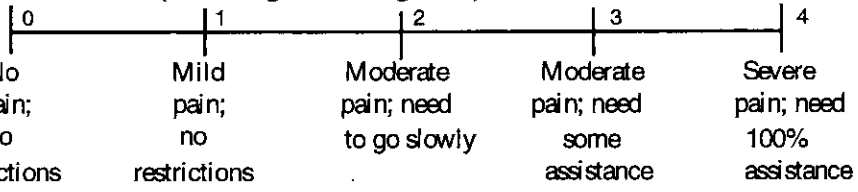
1. Pain Intensity



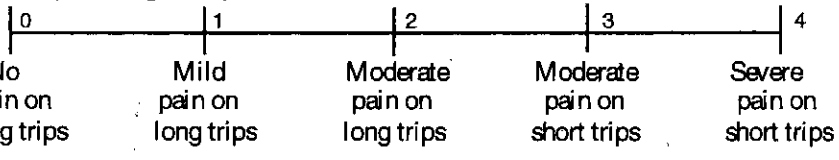
2. Sleeping



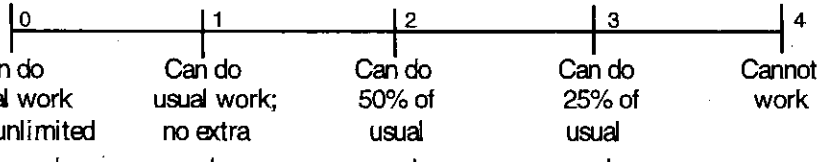
3. Personal Care (washing, dressing, etc.)



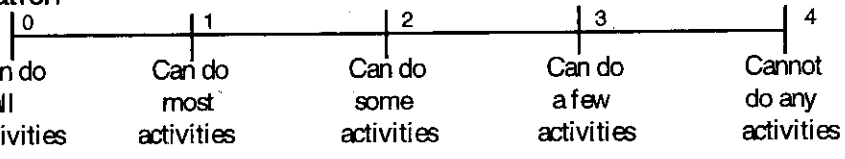
4. Travel (driving, etc.)



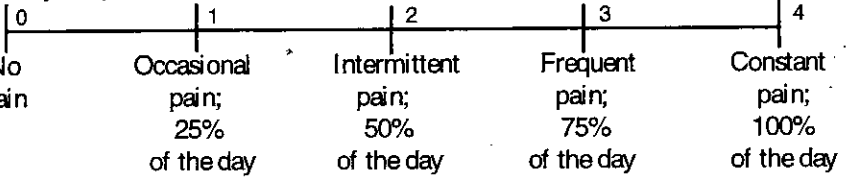
5. Work



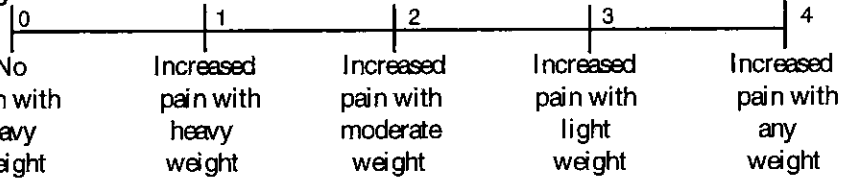
6. Recreation



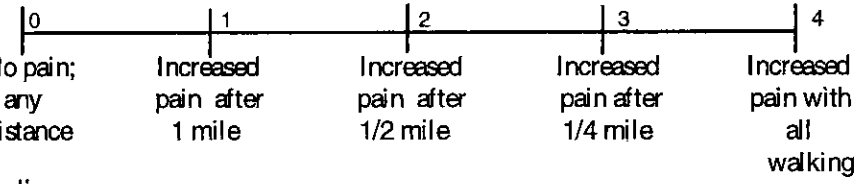
7. Frequency of pain



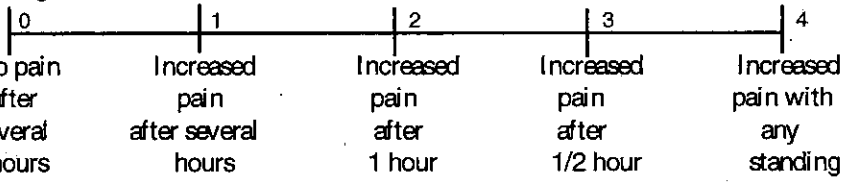
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

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_____

Signature

_____

Date