

Patient Health Questionnaire

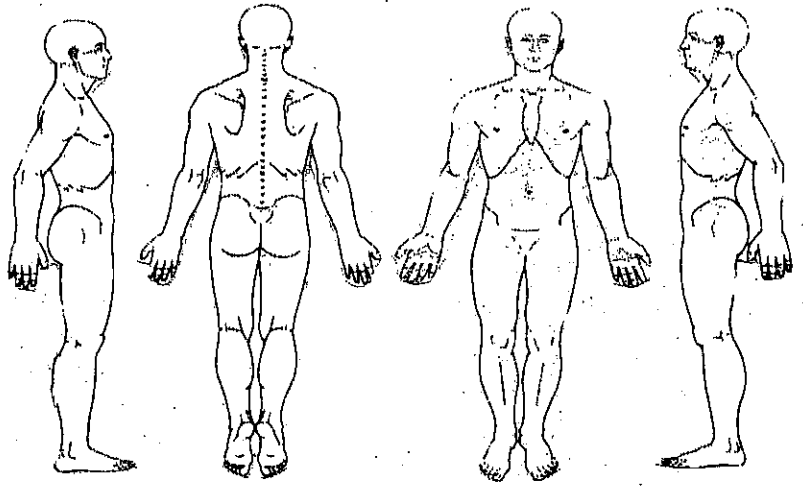
Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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:
  - Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10  
(0=none 10=Unbearable)
  - 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 1=Professional/Executive 4=Laborer 7=Retired  
Part Time 2=White Collar/Secretarial 5=Homemaker 8=Other  
3=Tradesperson 6=FT Student

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? \_\_\_\_\_

\_\_\_\_\_

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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**

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

**2. Sleeping**

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

**4. Travel (driving, etc.)**

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

**5. Work**

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

**6. Recreation**

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

**7. Frequency of pain**

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

**8. Lifting**

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

**9. Walking**

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

**10. Standing**

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name \_\_\_\_\_ PRINTED \_\_\_\_\_ ID#/SS# \_\_\_\_\_ Plan ID \_\_\_\_\_ Total Score \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_