Name of Ins Co_________________
Employer______________________
Ded_____ Copay______Coins______

PATIENT HEALTH QUESTIONAIRE

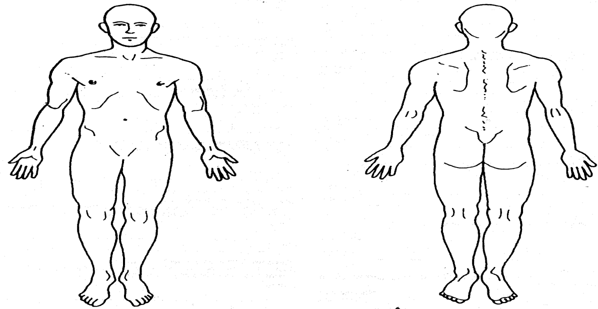
Name: ____ Date: ______/______/_______

In the space below, please describe your major complaint.
If you have an additional complaint, please describe on the back of this sheet.

Please Describe Your Complaint: ____
____
____

Description	Frequency
☐ Sharp Pain	☐ Constant (76-100%)
☐ Dull Ache	☐ Frequent (51-75%)
☐ Ache	☐ Occasional (26-50%)
☐ Weak	☐ Intermittent (25% or less)
☐ Throbbing	
☐ Numb	
☐ Shooting	
☐ Gripping	
☐ Burning	
☐ Tingling	

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



Indicate intensity of your pain at its lowest and highest level   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
Your symptoms are ☐ decreasing ☐ not changing ☐ increasing
Symptoms are worse in ☐ morning ☐ afternoon ☐ increase during the day ☐ same all day

When did your problem begin? (Specific date if possible) _______________ Describe how your problem began _______________________
____
____
Have you seen a Chiropractor before? ☐ Yes ☐ No IF yes, who and when____
Have you been treated for this episode? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ PT ☐ OT ☐ Other____________________________________
Are you currently being seen? ☐ Yes ☐ No
When and what treatment? ____/_____/____ ____
____

In the past have you been treated for the same or a similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ PT ☐ OT ☐ Other___________________
When and what treatment did you receive? ____
____

What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐Inactivity

What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

How would you rate your general stress level? ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

General Physical Activity: ☐ No regular exercise ☐ Light exercise program ☐ Moderate exercise program ☐ Strenuous exercise program

Are your complaints affecting your ability to be active?
☐ No Affect ☐ Some physical restrictions (able to perform light duty work or household tasks)
☐ Need limited assistance with common everday tasks ☐ Need assistance often
☐ Have a significant inability to function without assistance ☐ Am totally disabled (impaired). Cannot care for self

Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Heavy manual labor ☐ Repeated motion

Occupation: ____________________________ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No
What is your current work status?
☐ Full time, no restrictions ☐ Part time, with restrictions ☐ Unemployed ☐ Other __________________________
☐ Full time, with restrictions ☐ Off work due to restrictions ☐ Retired
☐ Part time, no restrictions ☐ Full time homemaker ☐ Full time student