

Patient Health Questionnaire

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name _____

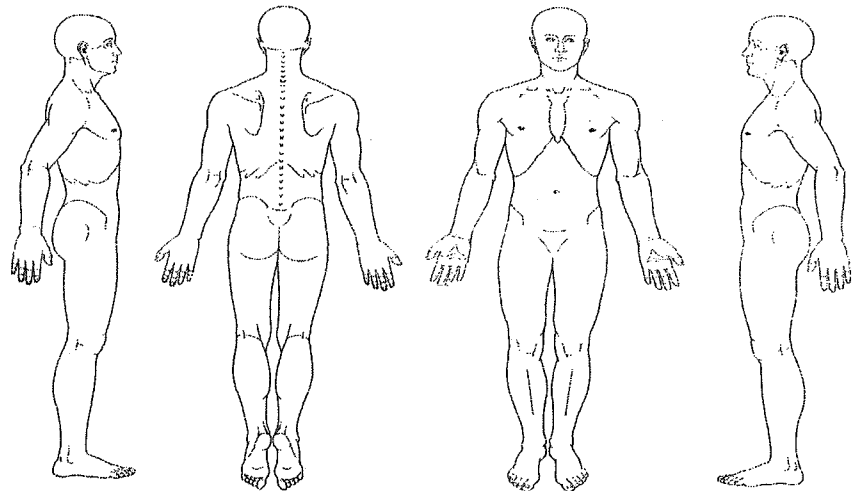
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



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. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ Severe, no activity possible

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

10. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

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

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature _____

Date _____

Patient Health Questionnaire - page 2

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ Date _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height

--	--	--

 Weight

--	--	--

 lbs.
Feet Inches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

- | | | |
|---|--|---|
| <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Upper Back Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Mid Back Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Back Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Wrist Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Hand Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip/Upper Leg Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee/Lower Leg Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Jaw Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint Swelling/Stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> General Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination</p> <p><input type="checkbox"/> <input type="checkbox"/> Visual Disturbances</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> | <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pains</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Bladder Infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of Appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Tumor</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis</p> | <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive Thirst</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Smoking/Use Tobacco Products</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Systemic Lupus</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV/AIDS</p> <p>Females Only</p> <p><input type="checkbox"/> <input type="checkbox"/> Birth Control Pills</p> <p><input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement</p> <p><input type="checkbox"/> <input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p>Other Health Problems/Issues</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> |
|---|--|---|

Indicate if an immediate family member has had any of the following:

- Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____