Date:

Centralia Chiropractic Center

PATIENT HEALTH QUESTIONNAIRE – Page 1

Please print legibly and fill out all relevant parts of the form completely. Use N/A if it is not applicable.

Patient Name _____ **Age** _____ **Occupation** _____

Describe your symptoms _____

_____

When did this problem begin? _____ **How did this problem begin?** _____

Was it related to an accident or injury? work / auto / other _____ / none of these

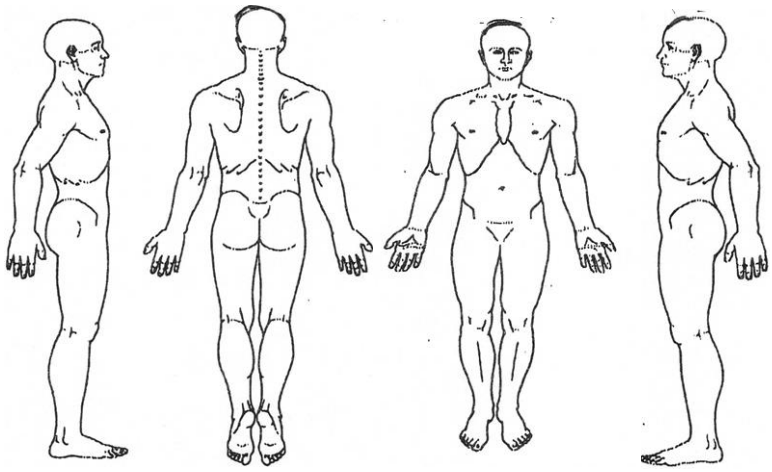
How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Aching
- ☐ Numb
- ☐ Stiffness
- ☐ Weakness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Tightness
- ☐ _____

Indicate where you have pain or other symptoms



How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

	None										Unbearable
Currently, at what level are your symptoms?	0	1	2	3	4	5	6	7	8	9	10
How bad are your symptoms at their: Worst	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

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

0	1	2	3	4	5	6	7	8	9	10
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

What activities make these symptoms worse? _____

What activities make these symptoms better? _____

Who have you seen for these symptoms? _____

When and what treatment? _____

What tests or imaging have you had and when were they done? X-rays date: _____ CT Scan date: _____ MRI date: _____ Other _____ date: _____

Have you had similar symptoms in the past? Yes / No If yes, when was your last episode? _____ and how often are these past episodes occurring? Daily / Weekly / Monthly / Yearly / Other _____

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

This Office / Medical Doctor / Other Chiropractor / Physical Therapist / Other _____

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

Reduce symptoms / Explanation of condition and treatment / How to prevent this from happening again / Resume or increase activity / Learn how to take care of this on my own / Other _____

Provider initials

Patient/Responsible Party Signature _____

Centralia Chiropractic Center
PATIENT HEALTH QUESTIONNAIRE – Page 2

Date:

Patient Name _____ **Height** ____ feet ____ inches **Weight** _____ pounds
Hand Dominance: Left / Right
Type of regular exercise? (Circle all that apply) Stretching / Strengthening / Cardio / Other _____
None / Light / Moderate / Strenuous How many times per week? _____

Mark all other current conditions NOT ALREADY ADDRESSED ON PAGE 1 with a "C" and past conditions with a "P".
For past conditions, indicate how long ago. Leave blank if it does not apply.

___ Headaches
___ Neck symptoms
___ Upper back symptoms
___ Mid back symptoms
___ Low back symptoms

___ Shoulder symptoms
___ Elbow/upper arm symptoms
___ Wrist/ lower arm symptoms
___ Hand symptoms

___ Hip/upper leg symptoms
___ Knee/lower leg symptoms
___ Ankle/foot symptoms

___ Jaw symptoms
___ Arthritis
___ Joint swelling/stiffness
___ Other _____

___ High blood pressure
___ Heart attack
___ Chest pains
___ Stroke
___ Angina

___ Kidney stones
___ Kidney disorders
___ Bladder infection
___ Painful urination
___ Loss of bladder control

___ Abnormal weight gain/loss
___ Loss of appetite
___ Pain around ribs
___ Ulcer
___ Abdominal pain

___ Other _____

___ Diabetes
___ Excessive thirst
___ Frequent urination

___ Tobacco use/Smoking
___ Alcohol / Drug dependency

___ Allergies
___ Systemic Lupus
___ Depression
___ Seizures
___ Rash/Dermatitis/Eczema
___ HIV/AIDS
___ Hepatitis
___ Liver/Gall bladder disorder
___ Gas
___ Constipation
___ Diarrhea
___ Other _____

___ Loss of sleep
___ General fatigue
___ Muscle incoordination
___ Dizziness
___ Ringing in ears
___ Vision changes

___ Cancer
___ Benign tumors/cysts
___ Chronic sinusitis
___ Asthma
___ Shortness of breath

Male Only
___ Prostate problems
Females Only
___ Pregnancy

___ Other _____

Indicate if an immediate family member has had any of the following: Cancer – type: _____
Rheumatoid Arthritis / Heart problems / Diabetes / Auto Immune / No serious conditions
Other serious conditions _____ Relationship to you: _____
Have you had any broken bones? Yes / No If yes, where in your body? _____
How did the bone break? _____ When? _____
Have you been in any accidents or had any serious injuries in the past? Yes / No If yes, when? _____
What type of accident/injury? Auto / Work / Fall / Other _____
What kind of injuries did you have? Mild / Moderate / Severe / None known
What parts of your body were injured? _____
Previous chiropractic care? Yes / No If yes, how long ago? _____ What for? _____
Recent spinal x-rays (within 10 years)? Yes / No if yes, where were the x-rays taken? _____
Medications: Yes / No If yes, list all current prescription and over the counter medications that you take and the reason you take them. _____

Supplements: Yes / No If yes, list all current supplements and vitamins as well as the dosage. _____

Surgeries: Yes / No If yes, list all the surgical procedures and the approximate dates.

Patient/Responsible Party Signature _____

Provider Initials