Vivie Therapy
REBUILDING YOUR BODY, MIND AND SPIRIT BACK-TOGETHER
8818 Saturn St. Los Angeles CA 90035
(310) 623-4444 www.Vivie.com

Patient Health Questionnaire (Page 1):

Patient Name _____ **Date:**_____/_____/20____

1. **Please describe your symptoms:** _____

   _____

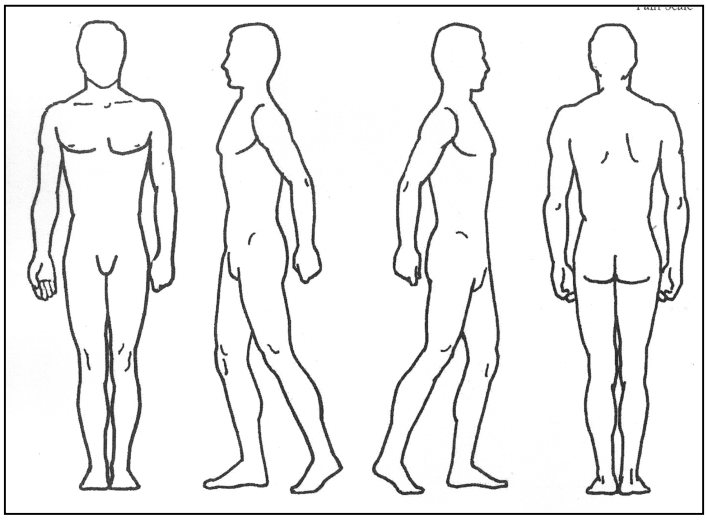
   When did your symptoms start?_____

   How did your symptoms begin?_____

   _____

2. **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)

   On the image below, mark where you have pain & other symptoms:



3. **What describes the nature of your symptoms?**
   - □ Sharp □ Shooting
   - □ Dull Ache □ Burning
   - □ Numb □ Tingling

4. **How are your symptoms changing?**
   - □ Getting Better
   - □ Not Changing
   - □ Getting Worse

5. **On a pain scale of 1-10, 1=no pain 10=unbearable pain, what number represents the average intensity of your pain over the last 4 weeks?** _____

6. **Over the last 4 weeks, how much has the pain interfered with your normal work (including work outside the home and housework)?**
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

   Over the last 4 weeks, how much has the pain interfered with your social activities?
   □ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

7. **In general would you say your overall health is…**
   □ Excellent □ Very Good □ Good □ Fair □ Poor

8. **Who have you seen for your symptoms?**
   □ No One □ Medical Doctor □ Chiropractor □ Physical Therapist □ Other _____

   What treatment did you receive and when? _____ **Date:**____/____/20____

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

   □ Xrays ____/_____/20_____ □ MRI ____/_____/20_____

   □ CT Scan ____/_____/20_____ □ Other____/_____/20_____

Patient Initial Here:_____

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Patient Health Questionnaire (Page 2):

Patient Name _____ **Date:**_____/_____/20____

9. **Have you had similar symptoms in the past?** □ Yes □ No

   If you have received treatment for similar symptoms in the past, who did you see?
   □ This Office □ Medical Doctor □ Chiropractor □ Physical Therapist □ Other _____

10. **What is your occupation?**

    _____

    If you are not retired, a homemaker, or a student, what is your current work status?
    □ Full Time □ Part Time □ Self Employed □ Unemployed □ Off Work □ Other _____

11. **What activities does your problem prevent you from doing?**
    □ Walking □ Reaching □ Bending □ Dressing
    □ Grooming □ Hygiene □ Housekeeping □ Driving
    □ Home Management
    □ Other: _____

12. **What medical equipment do you have at home?**
    □ Walker □ Wheelchair □Hospital Bed □ Commode □ Shower Equipment

13. **What is your current living situation?**
    □ Live alone □ Live with a caretaker □ Live with a family member

14. **Please list all medications and herbal supplements you are taking now**

    _____

15. **Please list any allergies:**

    _____

16. **Do you have any of the following medical conditions? (Check all that apply)**
    □ Diabetes Mellitus □ High/Low Blood Pressure □ Incontinence □ Defibrillator Implant
    □ Open Wounds □ History of Seizures □ Psychiatric History □ Radiation or Chemotherapy
    □ Osteoporosis □ Cancer or history of cancer □ Urinary Tract Infection □ Heart Disease/Hardening Arteries
    □ Sensory Deficits □ Immune System Compromise □ Respiratory Disease □ Arthritis
    □ Lymphedema/Lymphedema Treatments □ Pacemaker □ Neurological Disorder

    □ Other: _____

    □ Past Surgeries/Approximate Year: _____

17. **Answer the following statements by checking yes or no. Have you had:**

Yes	No	
□	□	an unexplained weight loss of greater than 10 lbs in the past month?
□	□	numbness in both hands and/or both feet at the same time?
□	□	any changes in your bowel or bladder habits?
□	□	any numbness in your backside, in the area where you would sit on a bicycle seat?
□	□	in coordination or weakness with walking?
□	□	any loss of balance or recent falls?

Patient Signature _____ **Date:**____/_____/20____