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**Patient Health Questionnaire (Page 1):**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_**

1. **Please describe your symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did your symptoms start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did your symptoms begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **How often do you experience your symptoms? On the image below, mark where you have pain & other 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)

1. **What describes the nature of your symptoms?**

Sharp Shooting

Dull Burning

Numb Tingling

1. **How are your symptoms changing?**

Getting Better

Not Changing

Getting Worse

1. **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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Over the last 4 weeks, how much has the pain interfered with your social activities?**

None of the time A small amount of the time Some of the time Most of the time All of the time

1. **In general would you say your overall health is**

Excellent Very Good Good Fair Poor

1. **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 you had for your symptoms and when were they performed?**

**\_\_\_\_\_\_**/\_\_\_\_\_/20\_\_\_\_MRI **\_\_\_\_\_\_**/\_\_\_\_\_/20\_\_\_\_Xrays

**\_\_\_\_\_\_**/\_\_\_\_\_/20\_\_\_\_Other **\_\_\_\_\_\_**/\_\_\_\_\_/20\_\_\_\_CT Scan

 **Patient Initial Here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient Health Questionnaire (Page 2):**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_**

1. **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What is your occupation?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Full Time Part Time Employed Unemployed Off Work Other:\_\_\_\_\_\_\_\_\_\_\_\_

1. **What activities does your problem prevent you from doing?**

Walking Reaching Bending Dressing Grooming Hygiene Housekeeping Driving Home Making Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What Medical equipment do you have at home?**

Walker Wheel Chair Hospital Bed Commode Shower Equipment

1. **What is your current living situation?**

Live Alone Live With a Caretaker Live with a Family Member

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Please List any allergies:**

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1. **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:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **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\_\_\_\_