PATIENT HEALTH QUESTIONNAIRE

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

_____ _____
Name Date

1) Please list and describe any symptoms you are having:

_____

_____

_____

How did your symptoms begin?_____

When did your symptoms start?_____

2) How often are you feeling your symptoms?
- □ All the Time
- □ Half Of the Day
- □ Occasionally
- □ Off and On
- □ Hardly Ever

3) What is the nature of your symptoms?
- □ Burning
- □ Numbness
- □ Dull and Achy
- □ Sharp
- □ Tingling
- □ Radiating
- □ Other:_____

4) During the last month:

On a scale from 1-10, how much does your pain interfere with your day?_____

On a scale from 1-10, how intense is your pain?_____

5) Overall, your health is:

□ Excellent □ Very Good □ Good □ Fair □ Unsatisfactory

6) Who have you received treatment from?

□ Chiropractor □ Medical Physician

□ Occupational Therapist □ Other:_____

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

□ X-rays date: _____ □ CT Scan date: _____

□ MRI date: _____ □ Other date: _____

8) Have you had any of the symptoms you are suffering from in the past? □Yes □No

9) What is your occupation? Does your injury impact your work?

_____

_____

10) Which of the following are not possible or extremely difficult because of your symptoms?

□ Bending Over □ Walking □ Keeping Up the House

□ Basic Hygiene □ Getting Dressed □ Reaching for things

□ Managing Your Home

□ Other:_____

11) Do you have any medical equipment at home?_____

_____

12) With whom do you live with?

□ Alone □ With a Caretaker □ With a Family Member(s)

13) Are you currently taking any medications? □ Yes □ No

If yes, please list and describe for what condition and how often:

_____

_____

_____

14) Please list any allergies that you have:_____

_____

_____

15) Do you suffer from any of the following issues or conditions?

□ Sensory Problems
□ Open Wounds (that won't heal)
□ Artificial Joints
□ Pacemaker implanted
□ Heart Disease
□ Respiratory Disease
□ Radiation/Chemotherapy
□ Other:_____

□ Kidney Problems
□ High or Low Blood Pressure
□ Arthritis
□ Respiratory Problems
□ Urinary Tract Infections
□ Neurological Disorders
□ Incontinence

□ Have you had any surgeries in the Past Year? If yes, please describe:

_____

16) Have you experienced any:

Numbness in one or both hands or feet?	□ Yes □ No
Numbness on your backside where you sit?	□ Yes □ No
Problems with coordination or weakness while walking?	□ Yes □ No
Loss of balance or taken a fall recently?	□ Yes □ No
Unexplained weight loss/gain of 10 lbs in the last month?	□ Yes □ No
Changes in your bladder or bowel habits?	□ Yes □ No

_____ _____

Name (Signature) Date