

PATIENT HEALTH QUESTIONNAIRE – PAGE 1

PATIENT NAME: FIRST _____ MIDDLE _____ LAST _____ BIRTH DATE _____ TODAY'S DATE _____

CHIEF SUBJECTIVE COMPLAINT: _____
(Briefly describe)

HISTORY OF PRESENT ILLNESS

Condition is due to: Work Injury Illness Other Auto Accident (please ask for and fill out Auto Accident Form)

How did your pain begin? No apparent reason Bending Lifting Fall Motor Vehicle Accident

Other, describe: _____

Have you had a similar episode before? No Yes **What have you been told is wrong?** _____

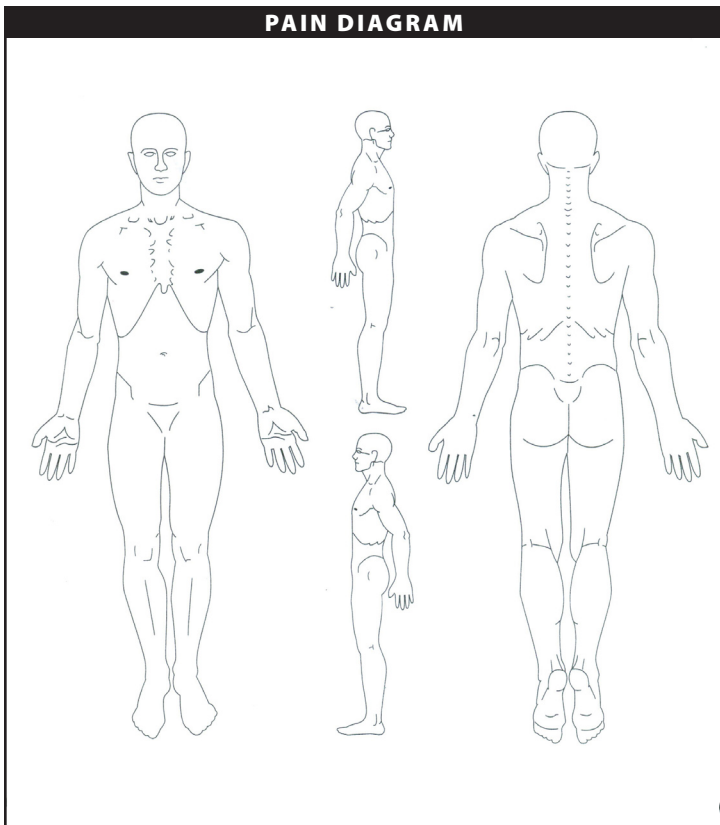
PAIN SPECIFICS

Please indicate the location of your pain on the pain diagram below. **When did your current condition begin?:** _____

Use these symbols to best describe the type(s) of pain:
D = Dull Ache **N** = Numbness **T** = Tingling (Pins & Needles)
B = Burning **S** = Sharp **C** = Numbness

- FREQUENCY OF PAIN:**
- Constantly (76%–100% of the day)
 - Frequently (51%–75% of the day)
 - Occasionally (26%–50% of the day)
 - Intermittently (0%–25% of the day)
 - Other

PAIN MEDICATION AND/OR MUSCLE RELAXERS:



ON THE SCALES BELOW, PLEASE DRAW A VERTICAL LINE REPRESENTING YOUR PAIN OR DISCOMFORT. ALSO, INDICATE EACH AREA OF PAIN BY DRAWING A LINE TO THE MATCHING AREA ON THE DIAGRAM:

Rate the FIRST area of pain you have:

NO PAIN UNBEARABLE PAIN

← _____

Rate the SECOND area of pain you have:

NO PAIN UNBEARABLE PAIN

← _____

Rate the THIRD area of pain you have:

NO PAIN UNBEARABLE PAIN

← _____

Rate the FOURTH area of pain you have:

NO PAIN UNBEARABLE PAIN

← _____

- | | |
|---|--|
| <p>PAIN BETTER:</p> <ul style="list-style-type: none"> <input type="checkbox"/> AM <input type="checkbox"/> At Rest <input type="checkbox"/> Mid-Day <input type="checkbox"/> Does Not Change <input type="checkbox"/> PM <input type="checkbox"/> Other | <p>PAIN WORSE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> AM <input type="checkbox"/> At Rest <input type="checkbox"/> Mid-Day <input type="checkbox"/> Does Not Change <input type="checkbox"/> PM <input type="checkbox"/> Other |
|---|--|

PATIENT HEALTH QUESTIONNAIRE – PAGE 2

SUBJECTIVE SYMPTOMS		
SYMPTOM	TIMING	
	PAST	PRESENT
PROBLEMS		
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Cold sweats	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Muscular incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
SENSORY	PAST	PRESENT
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Buzzing or ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>
Eyes sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
EMOTIONAL	PAST	PRESENT
Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Depression or crying spells	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>
DYSFUNCTION	PAST	PRESENT
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart irregularities	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Liver/gall bladder disorder	<input type="checkbox"/>	<input type="checkbox"/>
DISEASE	PAST	PRESENT
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>

ACTIVITY OF DAILY LIVING (ADL)					
(ADL)	ABILITY TO PREFORM ADL				
	Unable	Painful	Difficult	Limited	Other
SLEEP					
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying flat on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side with knees bent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEATED	Unable	Painful	Difficult	Limited	Other
Supine to sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting at a table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting to standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDING	Unable	Painful	Difficult	Limited	Other
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing for more than 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending sideways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING	Unable	Painful	Difficult	Limited	Other
Walking short distances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair/10 yards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VOCATIONAL	Unable	Painful	Difficult	Limited	Other
Operate car/machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMESTIC	Unable	Painful	Difficult	Limited	Other
Feeding self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress lower body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of perineum/clothing at toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash or bathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward to brush teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFER	Unable	Painful	Difficult	Limited	Other
Transfer – toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer – tub or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer – automobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR PAIN SPECIFICS

PRIOR TESTS FOR YOUR CURRENT CONDITION – TEST/RESULTS:

- X-ray _____
- MRI _____
- CT _____
- Lab _____
- Other _____

PRIOR TREATMENT FOR YOUR CURRENT PROBLEM:

- ANTI-INFLAMMATORY:** Ibuprofen Celebrex Vioxx
- Bextra Other, Results: _____
- STEROIDS:** Cortisone Pills Cortisone Injections
- Other, Results: _____
- OTHER MEDICATIONS:** _____
- Results: _____
- INJECTIONS:** Epidural Facet Other, Results: _____
- _____
- SPINAL SURGERY:** Year/Procedure/Results: _____
- _____
- PHYSICAL THERAPY:** Year/Procedure/Results: _____
- _____
- CHIROPRACTIC:** Year/Procedure/Results: _____
- _____
- OTHER TREATMENTS:** Year/Type/Results: _____
- _____

FOR PROVIDER USE ONLY:

PERSONAL MEDICAL HISTORY

SURGERIES/HOSPITALIZATIONS:

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

INJURIES/FRACTURES/DISLOCATIONS:

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

Have you had problems with anesthesia, infection, bleeding, or other surgical complications? No Yes Explain: _____

PAST PERSONAL HEALTH HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Other, _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Pacemaker | _____ |

FAMILY MEMBER HEALTH HISTORY

	FATHER	MOTHER	BROTHER	SISTER	OTHER
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other, _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT HEALTH QUESTIONNAIRE – PAGE 4

LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	STARTING DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: No Yes _____

FEMALE PATIENTS PERSONAL MEDICAL HISTORY

Are you possibly pregnant? No Yes Due Date: _____

Date of last menstrual cycle? Begin _____ End _____

PLEASE CHECK ITEMS THAT APPLY TO YOUR MEDICAL HISTORY:

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Lack of Bladder Control
- Menopause/Hot Flashes
- Number of Children _____
- Complications During Pregnancy or Delivery? _____

MALE PATIENTS PERSONAL MEDICAL HISTORY

PLEASE CHECK ITEMS THAT APPLY TO YOUR MEDICAL HISTORY:

- Prostate Problems
- Pain in Penis
- Painful Urination
- Lack of Bladder Control
- Sexual Problems

PATIENT SLEEP PATTERNS

Sleep Position:	Sleep Description:	
<input type="checkbox"/> Back	<input type="checkbox"/> Deep & Recuperative	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Stomach	<input type="checkbox"/> Restless & Recuperative	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Side	<input type="checkbox"/> Deep & Unrecuperative	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> All	<input type="checkbox"/> Restless & Unrecuperative	<input type="checkbox"/> Night Terrors
<input type="checkbox"/> Sitting	<input type="checkbox"/> Awakened Several Times	<input type="checkbox"/> Pain/Stiffness
<input type="checkbox"/> Other _____	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Other _____

PATIENT DIET

Diet Type:	Diet Consistency:
<input type="checkbox"/> Typical Western	<input type="checkbox"/> 3 Meals a Day with Snacks
<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Inconsistent
<input type="checkbox"/> Vegan	<input type="checkbox"/> 2 Meals a Day with Snacks
<input type="checkbox"/> Low Fat	<input type="checkbox"/> Constant Snacking
<input type="checkbox"/> Low Carb	<input type="checkbox"/> Specialized
<input type="checkbox"/> Low Calorie	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetic	
<input type="checkbox"/> Other _____	

PATIENT WORK STATUS

Current Work Status:

- Regular Duty
- Limited/Light Duty, Date Light Duty Began: _____
- Off Work, Date Taken Off Work: _____

Occupation:

HOURS PER DAY SPENT SITTING

- Domestic/Home maker _____
- Office _____
- Truck Driver _____
- Labor _____
- Construction _____
- Sales (Standing Most of the Day) _____
- Public Service (Mail Carrier/Fireman/Policeman) _____
- Military _____
- Other _____

PERSONAL LIFE STYLE

Exercise:	DURATION	TIMES PER WEEK
<input type="checkbox"/> Walk	_____	_____
<input type="checkbox"/> Jog	_____	_____
<input type="checkbox"/> Run	_____	_____
<input type="checkbox"/> Aerobic	_____	_____
<input type="checkbox"/> Pilates	_____	_____
<input type="checkbox"/> Yoga	_____	_____
<input type="checkbox"/> Biking	_____	_____
<input type="checkbox"/> Weight Lifting	_____	_____
<input type="checkbox"/> Swimming	_____	_____
<input type="checkbox"/> Elliptical	_____	_____
<input type="checkbox"/> Core Training	_____	_____
<input type="checkbox"/> Other _____		

Interests/Other Activities:

HOURS PER DAY SPENT SITTING

- Crafts/Creative Hobbies _____
- Garage/Shop _____
- Sports Fan _____
- Social Events _____
- Hunting/Fishing _____
- Shopping _____
- Family Time _____
- Other _____

PATIENT STRESS

Stress Factors:	Domestic Violence:
<input type="checkbox"/> Work	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Home	
<input type="checkbox"/> Relationship	
<input type="checkbox"/> Other _____	
Support System:	
<input type="checkbox"/> Family	
<input type="checkbox"/> Relationship	
<input type="checkbox"/> Church	
<input type="checkbox"/> Therapist	
<input type="checkbox"/> Other _____	

PATIENT HEALTH QUESTIONNAIRE – PAGE 5

PATIENT BOWEL HABITS

- Infrequent
- Incomplete
- Hard
- Straining During Defecation
- Does not Defecate Everyday
- Each Night
- Constipation
- Diarrhea
- Other _____
- Painful–Hemorrhoids
- Painful–Anal Fissures
- Spinal Cord Injuries
- Scleroderma
- Hirschspring’s Disease
- Secretory
- Osmotic
- Exudative
- Motility Disorder

PATIENT URINARY HABITS

- Stop & Go
- Going
- Stopping
- Incontinence
- Retention
- Blood in Urine
- Painful
- Other _____

PATIENT TREATMENT GOAL EXPECTATIONS

- Return to General Health
- Decrease Pain
- Decrease Inflammation
- Decrease Muscle Tension
- Decrease Compensatory Patterns
- Increase Mobility
- Increase Strength
- Restore Function
- Restore Posture
- Patient Education
- All of the Above

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all services rendered. I also understand that as a courtesy to me, _____ will bill my insurance company directly. I further understand that I am financially responsible for any services rendered that are not covered by my insurance company.

PATIENT SIGNATURE

DATE

CONSENT TO TREAT A MINOR

I hereby authorize the doctor to render care as deemed necessary
to my _____(relationship to child).

NAME OF CHILD

GUARDIAN SIGNATURE

DATE