

Patient Health Questionnaire

Account: _____

Name: _____

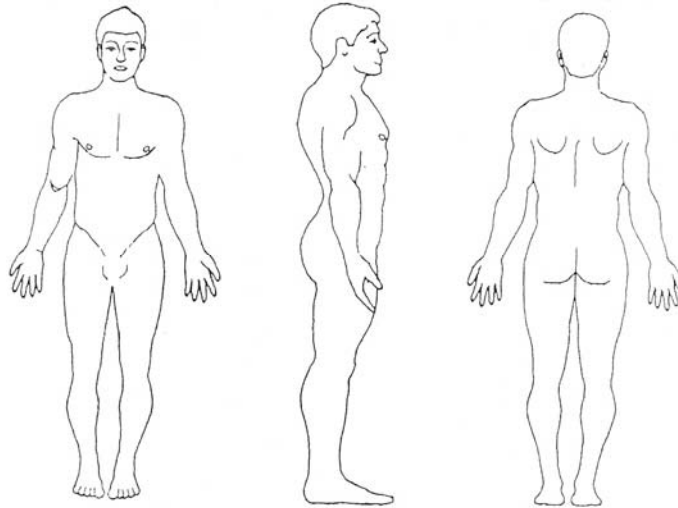
Age: _____

Date: _____

Mark on the picture where you are having symptoms and check the boxes as to the type of pain and frequency of pain.

A. Description (Mark all that apply.)

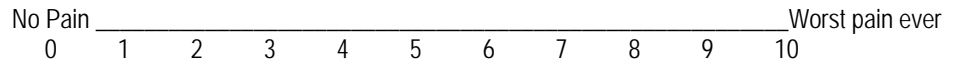
- Sharp Pain
- Dull Pain
- Ache
- Weak
- Throbbing
- Numbness
- Shooting
- Gripping
- Burning
- Tingling



B. Frequency

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)

C. Please mark on the line your current level of pain.



D. Your symptoms are: Decreasing Not Changing Increasing

E. What makes your problem better? (Mark all that apply)

- Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity Work Sleep

F. What makes your problem worse? (Mark all that apply)

- Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity Work Sleep

G. When did your problem begin? (Specific date if possible) : _____

H. Describe how your problem began: _____

I. Who else have you seen for this condition? _____

I. Please list prior major illnesses: _____

J. Please list prior major surgeries: _____

K. Please list medications you are taking and why: _____

Yes No

-Do you take minerals, herbs or vitamins? if yes, please list:

-Have you seen a chiropractor before? If yes, who, and when?

When did you last have:

Never <3 year Longer

- Physical exam Any problems revealed in the exam?

- X-rays