

# Patient Health Questionnaire Information

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M / F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phoned: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**Patient ID#:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_

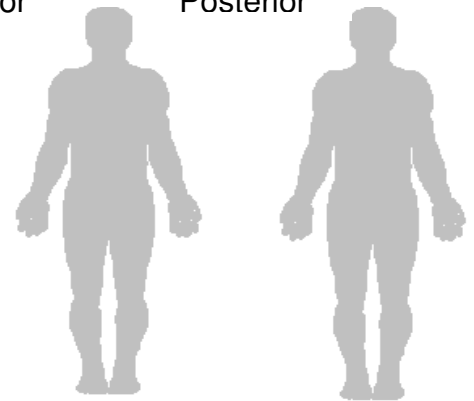
**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS**

**Describe your current problem and how it began:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Anterior

Posterior



**CURRENT CONDITION (How you feel today):**

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

No Pain

Unbearable

How often are your symptoms present ? [ ] 0 – 25% [ ] 26 – 50% [ ] 51 – 75% [ ] 76 – 100%

Can you perform your daily activities ? [ ] Yes [ ] No Describe: \_\_\_\_\_

Have you had Spinal X-rays, MRI, CT Scan ? [ ] No [ ] Yes Dates(s) Taken: \_\_\_\_\_

What areas were taken ? \_\_\_\_\_

**Please check all of the following that apply to you:** Family History: [ ] Cancer [ ] Diabetes [ ] High BP [ ] Stroke

NO YES <i>Condition</i>	NO YES <i>Condition</i>	NO YES <i>Condition</i>
[ ] [ ] History of Recent Infection	[ ] [ ] Urinary Retention	[ ] [ ] Visual Disturbances
[ ] [ ] Recent Fever	[ ] [ ] Aortic Aneurysm	[ ] [ ] Low/Mid Back Pain
[ ] [ ] HIV/AIDS	[ ] [ ] Cancer/Tumor	[ ] [ ] Neck Pain
[ ] [ ] Diabetes	[ ] [ ] Osteoporosis	[ ] [ ] Arthritis
[ ] [ ] Corticosteroid Use	[ ] [ ] Recent Trauma	[ ] [ ] Alcohol Use
[ ] [ ] Birth Control Pills	[ ] [ ] Prostate Problems	[ ] [ ] Tobacco Use
[ ] [ ] High Blood Pressure	[ ] [ ] Frequent Urination	[ ] [ ] Surgeries / Medications: _____
[ ] [ ] Stroke date: _____	[ ] [ ] Pregnancy, # of births _____	
[ ] [ ] Dizziness/Fainting	[ ] [ ] Abnormal Weight ___ Gain ___ Loss _____	

I certify the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through my provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I give permission to my chiropractor to contact my physician if my condition needs to be co-managed.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_