Date: 01/13/2023__________

Patient Name: ____

Address: ____

City, State, Zip: ____

Sex: M F

Age: ________

Birth date: _________________

Single **Married** **Widowed** **Separated** **Divorced**

Patient Social Security #: ______________________________

Occupation: ____

Employer: ____

Spouse's Name: _____________________________________

Home #: ___________ **Work #:**___________________

Cell #: _____________ **Email Address:** _________________________

In Case of Emergency, contact: __________________________________

Phone: ___________________________________

Whom may we thank for referring you? __________________________

PATIENT HEALTH QUESTIONNAIRE

Patient Name:________________________________ Date:________________

Describe your symptoms:____

____

____

When did your symptoms start?____

How did your symptoms begin?____

How often do you experience your symptoms?

a. Constantly (76-100% of the day)
b. Frequently (51-75% of the day)
c. Occasionally (26-50% of the day)
d. Intermittently (0-25% of the day)

What describes the nature of your symptoms?

Sharp	Shooting
Dull Ache	Burning
Numb	Tingling

How are your symptoms changing?

a. Getting Better
b. Not Changing
c. Getting Worse

During the past 4 weeks:

a. Rate the average intensity of your symptoms on a scale of 1 to 10 (1 being none and 10 unbearable):___________
b. How much has pain interfered with your normal work (including both work outside the home and housework)?
   1. Not at all   2. A little bit   3. Moderately   4. Quite a bit   5. Extremely

During the past 4 weeks, how much of the time has your condition interfered with social activities?

1. All of the time
2. Most of the Time
3. Some of the time
4. A little of the time
5. None of the time

In general, would you say your overall health right now is ….

1. Excellent   2. Very Good   3. Good   4. Fair   5. Poor

Who have you seen for your symptoms?

1. No one
2. Other Chiropractor
3. Medical Doctor
4. Physical Therapist
5. Other

What treatment did you receive and when?______________________________________

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

Xrays date:__________ CT Scan date:___________

MRI date:__________ Other date:___________

Have you had similar symptoms in the past? Y / N
If yes, who did you see?______________________________________
Do you, or anyone in your family, have a history of (please check):

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__Coughing Blood
__Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Diabetes
__Ulcers
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression

Do you have a history of stroke or hypertension?___________
Do you take medications?___ Please list them:__________________________________
____
____
Do you drink alcoholic beverages?___ If so, how much per week?____________
Do you use any tobacco products?_____ If so, amount per day: ________________
Do you take vitamin supplements?_____If so, please list:
____
Do you consume caffeine?____ If so, how much per day:_________________________
Do you exercise?__________ If yes, what is the frequency and type of exercise?____
What are your hobbies?____
What percentage of time during the day do you spend:
lifting_____ sitting_____ bending______ working at a computer_______

Patient Signature:________________________________ Date: 01/13/2023

Office Use Only

Diagnosis:____

Ortho/Neuro Findings:
____
____
____
____
____

X-Ray
Findings:____
____
____
____
____