PATIENT HEALTH QUESTIONNAIRE

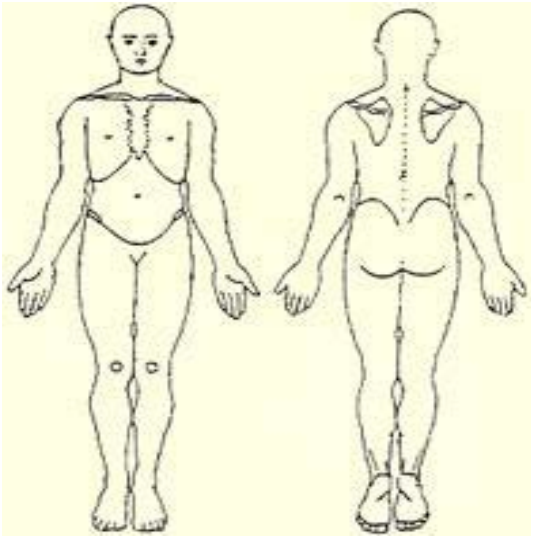
Name: _____ Birth Date: ____/_____/_____
Today's Date: _____/_____/_____

Describe your current complaint:

_____

_____

Please use the picture below to indicate the affected areas.



Describe the nature of your pain:

- ❑ Dull (pain) Ache
- ❑ Sharp Pain
- ❑ Throbbing
- ❑ Shooting
- ❑ Tingling
- ❑ Numbness
- ❑ Burning

Please circle:
Current pain level at rest:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Pain Intensity with movement:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Aggravating activities_____
_____
Easing activities _____
_____

Please list any surgeries or hospitalizations:

Date	Surgery/Hospitalization
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (fractures, dislocations, sprains etc.)

Date	Injury
_____	_____
_____	_____
_____	_____

Have you been treated for the same problem in the past? ❑ Yes ❑ No
If yes, by whom?

❑MD ❑Physical Therapist ❑Occupational Therapist ❑Chiropractor

❑Other_____

Have you had any of the following?

❑ MRI ❑ X-Ray ❑ CT ❑other
_____

Please list all prescription and over the counter medication, vitamins and supplements you are currently taking.

_____
_____
_____
_____

Have you ever been diagnosed as having any of the following? Please check all that apply.

❑ Heart problems
❑ Psychiatric problems
❑ Hypo/Hyper Glycemic
❑ Cancer
❑ High blood pressure
❑ Low blood pressure
❑ Stroke
❑ Tumor
❑ Asthma
❑ Diabetes
❑ Epilepsy
❑ Other arthritic condition
❑ HIV/AIDS
❑ Kidney Disease
❑ Seizures
❑ Allergies
❑ Drug or Alcohol Dependence
❑ Nervous problems
❑ Stomach problems
❑ Vascular problems
❑ Multiple Sclerosis
❑ Thyroid problems
❑ Ulcer
❑ Headaches
❑ Cysts
❑ Hepatitis
❑ Systemic lupus
❑ Arthritis
❑ Emphysema
❑ Tuberculosis
❑ Anemia
❑ Osteoporosis/Osteopenia
❑ Phlebitis
❑ Herpes

Are you currently pregnant? _____
Do you have a pacemaker? _____
Do you have any metal implants? _____