

Patient Health Questionnaire

Patient Name: _____ Today's Date: _____

Age: _____ Sex: Male Female Marital Status: Single Married/Partnered Widowed Divorced

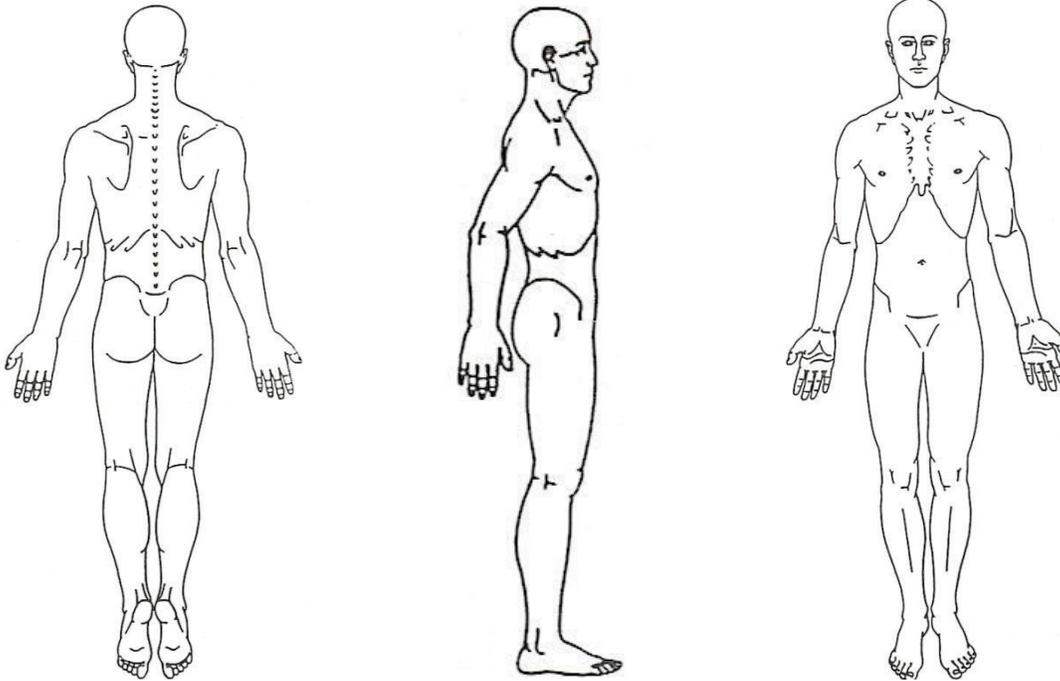
Children: Yes No How many? _____

Resides With: Alone Spouse/Partner Parents Children Other: _____

Social Security #: _____ Occupation: _____

Employer Name and Phone Number: _____

Please indicate for which body region you are seeking treatment (circle):



When did your symptoms begin? _____

How often do your symptoms occur?

Occasional Intermittent Frequent Constant Other: _____

Was your pain a result of an accident or injury? Yes No

If yes, please explain _____

Using a scale of 0-10 (10 being extreme) how would you rate your pain? _____ At present _____ At best _____ At worst

What activities/positions aggravate your condition? _____

What activities/positions relieve your condition? _____

Have you had any treatment associated with this condition? (Ex. OTC or Rx medications, physical therapy, chiropractic care, surgical consult, injections) If so please list dates and treatments.

Date	Treatment

Have you ever been diagnosed with or had any of the following? (Please check all that apply)

- Rheumatoid arthritis
- Chronic headaches
- Bleeding disorders
- High cholesterol
- Recent unexplained weight loss
- Joint replacement
- Irregular heartbeat
- Metal implants/pacemaker
- Asthma/COPD
- HIV/AIDS
- Lupus
- Diabetes
- Head injury/concussion
- Blood clots
- Cancer
- Stroke/MI
- Osteoporosis
- High blood pressure
- Seizure disorder
- Other _____

Please indicate whether you are RIGHT or LEFT handed: _____

- Do you smoke? Yes No How much? _____
- Do you drink alcohol? Yes No How many drinks per week? _____
- Do you drink caffeinated beverages? Yes No How many per day? _____
- How much water do you drink per day? _____
- Do you have a primary care doctor? Yes No Doctor's name and address: _____

Do you have a chiropractor? Yes No Name and Address _____

Have you been hospitalized in the past five years? Yes No

Please explain _____

Have you ever had surgery? Yes No If yes, please list type of surgery and year

Are you currently pregnant or trying to get pregnant? Yes No

Are you currently taking any medications on a daily basis? Yes No If yes, please list medication and dose (or attach copy of list)

Do you have any allergies to medicine? Yes No If yes, please list medication and reaction

Are you currently taking any supplements on a daily basis? Yes No If yes, please list

What are your goals while receiving treatment in our office and the timeframe:

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date _____