PATIENT HEALTH QUESTIONNAIRE *MONTGOMERY FAMILY CHIROPRACTIC*

PATIENT NAME: _____ **DATE:** _____

1. Describe your symptoms: _____

_____

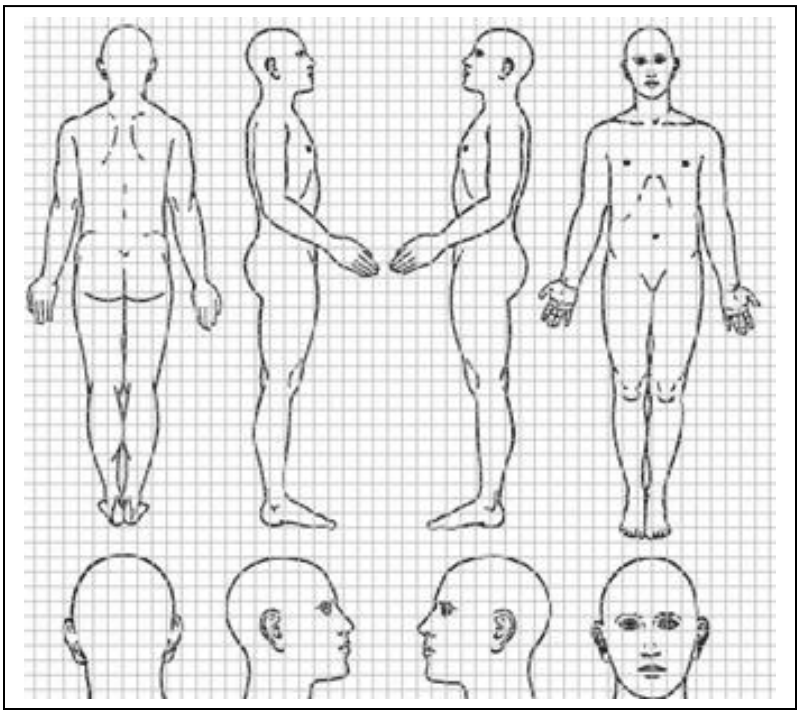
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

1) Constantly (76-100% of the day)
2) Frequently (51-75% of the day)
3) Occasionally (26-50% of the day)
4) Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

1) Sharp 4) Shooting
2) Dull ache 5) Burning
3) Numb 6) Tingling

4. How are your symptoms changing?

1) Getting better
2) Not changing
3) Getting worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None Unbearable
0 1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside of the home, and housework)

1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely

6. During the <u>past 4 weeks</u>, how much of the time has your condition interfered with your 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

7. In general how would you say your overall health is right now?

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

8. Who have you seen for your symptoms? 1) No one 3) Medical Doctor 5) Other
2) Other Chiropractor 4) Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms And when were they performed? 1) Xrays *date:* _____ 3) CT scan *date:* _____ 2) MRI *date:* _____ 4) Other *date:* _____

9. Have you had similar symptoms in the past? 1) Yes 2) No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? 1) This office 3) Medical Doctor 5) Other 2) Other Chiropractor 4) Physical Therapist

Patient Signature:_____ **Date:** _____

Patient Health Questionnaire- page 2 ***MONTGOMERY FAMILY CHIROPRACTIC***

Patient Name: _____ **Date:** _____

What type of regular exercise do you do? 1) None 2) Light 3) Moderate 4) Strenous

What is your height and weight? Height: _____ Weight: _____lbs.

For each of the conditions listed below, place a check mark in the *PAST* column if you have had the condition in the past. If you presently have a condition listed below, place a check mark in the *PRESENT* column.

Past	Present		Past	Present		Past	Present	
__	__	Headaches	__	__	High Blood Pressure	__	__	Diabetes
__	__	Neck Pain	__	__	Heat Attack	__	__	Excessive thirst
__	__	Upper back pain	__	__	Chest Pains	__	__	Frequent urination
__	__	Mid-back pain	__	__	Stroke			
__	__	Low back pain	__	__	Angina	__	__	Tobacco products
						__	__	Drugs/Alcohol
__	__	Shoulder pain	__	__	Kidney stones			
__	__	Elbow/ arm pain	__	__	Kidney disorders	__	__	Allergies
__	__	Wrist pain	__	__	Bladder infection	__	__	Depression
__	__	Hand pain	__	__	Bladder control	__	__	Systemic Lupus
			__	__	Prostate problems	__	__	Dermatitis/eczema
__	__	Hip/upper leg pain				__	__	HIV/AIDS
__	__	Knee/lower leg pain	__	__	weight gain/loss			
__	__	Ankle/foot pain	__	__	appetite loss			**Females only**
			__	__	abdominal pain	__	__	Birth control pills
__	__	Jaw pain	__	__	Ulcer	__	__	Hormone therapy
__	__	Joint swelling/stiffness	__	__	Hepatitis	__	__	Pregnancy
__	__	Arthritis	__	__	Liver/Gall bladder			
__	__	Rheumatoid arthritis	__	__	Cancer			**Other health issues?**
__	__	General fatigue	__	__	Tumor			
__	__	Muscular Incoordination	__	__	Asthma			
__	__	Visual disturbances	__	__	Chronic sinusitis			
__	__	Dizziness						

Indicate if an immediate family member has had any of the following:

O Rheumatoid arthritis O Heart problems O Diabetes O Cancer O Lupus O_____

List all prescriptions and over-the-counter medications, and nutritional supplements you are taking:

_____

_____

List all surgical procedures and times that you have been hospitalized if any:

_____

Patient Signature: _____ **Date:** _____

Additional Comments: _____

_____

_____

_____

Doctor's Signature: _____ **Date:** _____