Morris CHIROPRACTIC

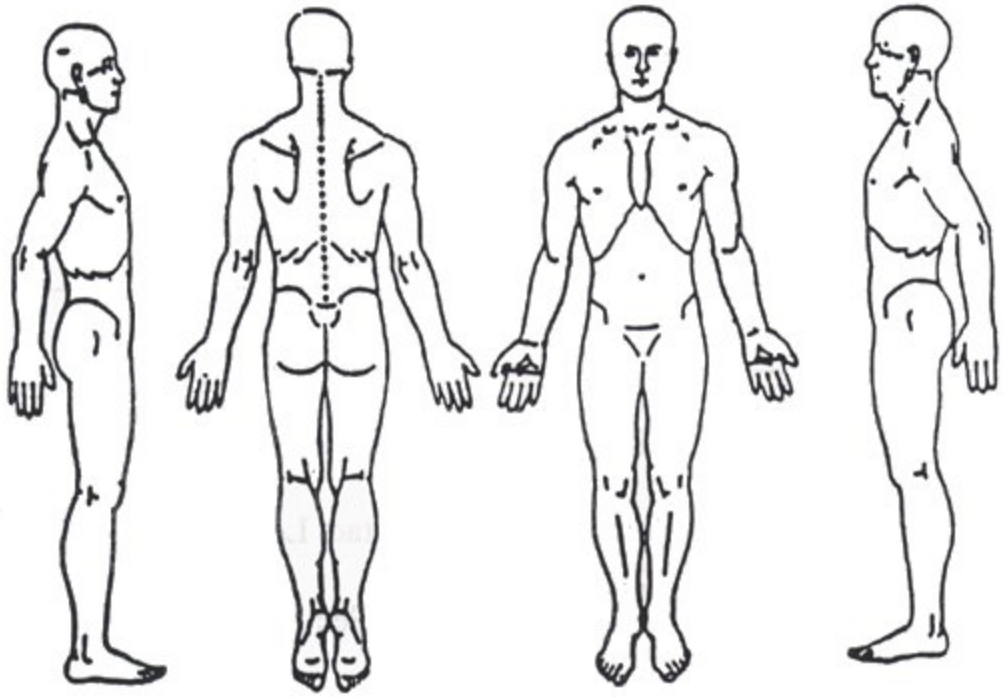
Patient Health Questionnaire **Date:**_____

Patient Name:_____

Today I am here because I am having…

□ pain □ soreness □ tension □ discomfort
□ weakness □ numbness □ tingling □ pins and needles

□ other _____as indicated on the body diagram below:



My symptoms are

□ dull □ sharp □ burning □ aching
□ stabbing □ deep □ vice like □ throbbing
□ other _____

Using the following pain scale to indicate the average intensity of your symptoms for each area marked on the body diagram:

No Pain Unbearable Pain
0 1 2 3 4 5 6 7 8 9 10

If you are having headaches, do any of the following also occur?

□ nausea/vomiting □ tremor □ dizziness □ weakness
□ vision problems □ light/sound sensitivity
How often do they occur? _____times /week or _____times/month. How long do they last? _____

My symptoms…

□ began □ returned □ increased □ suddenly □ gradually
□ today 1, 2, 3, 4, 5, 6 (circle one) □ days □ weeks □ other_____ago.

My symptoms began as a result of…

□ lifting □ bending □ reaching □ stumbling/trip
□ falling □ yard work □ traveling □ auto accident
□ work injury □ sports injury □ stress □ other_____

Since the onset of this episode, overall I am getting…

□ better □ worse □ staying the same □ better, but then worse again

How often do you experience your symptoms?

□ constantly (75-100% of the day) □ intermittently (25-50% of the day)
□ frequently (50-75% of the day) □ occasionally (1-25% of the day)

My symptoms are worse in the…

□ morning □ afternoon □ evening □ night

They are worse with…

□ prolonged sitting _____mins. □ prolonged standing _____mins.
□ walking _____(how long) □ standing from sitting
□ lying down □ turning in bed
□ bending □ reaching
□ looking up □ looking down
□ coughing □ sneezing
□ turning head □ stress
□ other_____ □ getting in/out of the car

My symptoms are better with…

□ sitting □ standing □ walking □ other_____
□ exercising □ stretching □ lying down

Treatment with..

□ ice □ heat □ massage □ medication □ other_____

I □ have had / □ am having other treatment for this condition from a…

□ medical doctor □ physical therapist □ chiropractor
□ massage therapist □ acupuncturist □ other_____

What was the diagnosis?_____

Date(s) of visit:_____Result:_____

_____

I □ have / □ have not missed work due to this condition.

I have noticed a change in my bodily functions marked below:

□ balance □ bowel habits □ breathing □ coordination
□ coughing □ gait/walking □ grip □ hearing
□ menstrual □ sexual □ sleep □ sneezing
□ urination □ vision □ weight □ other_____

I □ have / □ have not recently had an infection or other illness.
I □ am / □ am not currently under a doctors care for any other conditions.
I □ am / □ am not / □ may be pregnant - _____weeks _____months.

Are there any other changes in health, prescribed medications, surgeries, hospitalizations since you were last seen in our office?_____

_____

_____