



**Patient Health Questionnaire**

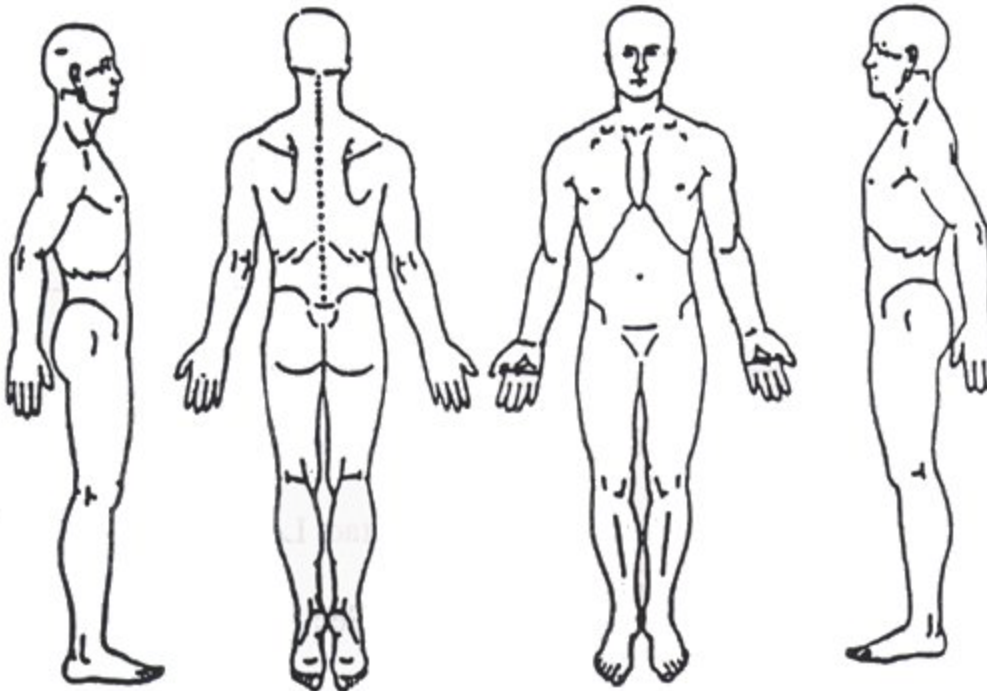
**Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

Today I am here because I am having...

- pain
- weakness
- soreness
- numbness
- tension
- tingling
- discomfort
- 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)
- frequently (50-75% of the day)
- intermittently (25-50% 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: \_\_\_\_\_

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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? \_\_\_\_\_

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