White CHIROPRACTIC

PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date: _____

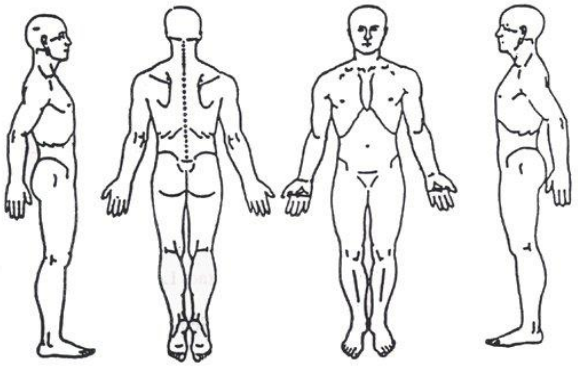
HISTORY OF PRESENT COMPLAINT

What is your chief complaint? _____

When did your symptoms start? _____ Describe how they began: _____

Where is the pain/problem? _____

Circle on the diagram where you experience your symptoms



How does the pain feel? (circle all that apply):
Sharp, Shooting, Dull, Achy, Burning, Numbness, Tingling

Severity: How severe is pain/problem on a scale of 0-10
0 1 2 3 4 5 6 7 8 9 10 (10=most severe)

Time of day you notice the pain/problem:
☐ Morning ☐ Afternoon ☐ Evening

How often do you experience your symptoms?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Does this pain wake you up at night? ☐ Yes ☐ No

What other problems have you been experiencing? _____

How do your symptoms affect your ability to perform daily activities? (please circle one)

No complaints	☐ Mild, forgotten with activity	☐ Moderate, interferes with activity	☐ Limiting, prevents full activity	☐ Intense, preoccupied with seeking relief	☐ Severe, no activity possible

What makes your symptoms worse? _____
What makes your symptoms better? _____
Who else have you seen for your symptoms? _____
When and what treatment was given? _____
Did you have any specific tests performed by other practitioner? _____
(X-Rays, MRI, CT Scan, Blood Tests, etc.)

Have you had similar symptoms in the past? ☐ Yes ☐ No
If yes, please describe: _____ How were symptoms relieved? _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No
Name of Chiropractor: _____
Date of last treatment: _____
Did they take x-rays? ☐ Yes ☐ No
What did you like or dislike about treatment? _____

List all prescription and over-the-counter medications you are taking:	List all nutritional/herbal supplements you are taking:	List all hospitalizations/surgeries you have had:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been in an auto accident? ☐ Past Year ☐ Past Five Years ☐ Over Five Years
Describe: _____
Other significant injuries: _____

Review of Systems

Past	Present		Past	Present		Past	Present	
		EENT			**Genitourinary**			**Neurological**
☐	☐	Eye Disease/Injury	☐	☐	Frequent Urination	☐	☐	Light Headed or Dizzy
☐	☐	Blurred or Double Vision	☐	☐	Painful/Burning Urination	☐	☐	Fainting
☐	☐	Hearing Loss or Ringing	☐	☐	Recurrent Bladder/Kidney Infections	☐	☐	Confusion
☐	☐	Earaches/Infections	☐	☐	Yeast Infections	☐	☐	Numbness/Tingling
☐	☐	Chronic Sinus Problems	☐	☐	Bloody/Discolored Urine	☐	☐	Convulsions/Seizures
☐	☐	Chronic Sore Throats	☐	☐	Incontinence	☐	☐	Tremors
☐	☐	Nose Bleeds	☐	☐	Kidney Stones	☐	☐	Paralysis
		Cardiovascular	☐	☐	Sexual Difficulty	☐	☐	Head Injury
☐	☐	Chest Pain			**Males**			**Psychiatric**
☐	☐	Heart Palpitations	☐	☐	Testicular Problems/Pain	☐	☐	Nervousness/Anxiety
☐	☐	Shortness of Breath	☐	☐	Prostate Problems	☐	☐	Depression
☐	☐	High Blood Pressure			**Females**	☐	☐	Mental Illness
☐	☐	Stroke	☐	☐	Painful Periods			**Endocrine**
☐	☐	Varicose Veins	☐	☐	Irregular Periods	☐	☐	Thyroid Problems
		Respiratory	☐	☐	Fertility Issues	☐	☐	Other Glandular Problems
☐	☐	Chronic Cough	☐	☐	Abnormal PAP	☐	☐	Hormonal Problems
☐	☐	Coughing Up Blood			**Musculoskeletal**	☐	☐	Excessive Thirst/Urination
☐	☐	Wheezing	☐	☐	Headaches	☐	☐	Excessive Fatigue
		Gastrointestinal	☐	☐	Low Back Pain	☐	☐	Heat/Cold Intolerances
☐	☐	Change in Appetite	☐	☐	Mid Back Pain	☐	☐	Sudden Weight Gain/Loss
☐	☐	Nausea or Vomiting	☐	☐	Neck Pain	☐	☐	Skin Changes
☐	☐	Heartburn	☐	☐	Shoulder Pain			**Hematologic**
☐	☐	Ulcers	☐	☐	Elbow, Wrist, Hand Pain	☐	☐	Hemophilia
☐	☐	Change in Bowel Mvts.	☐	☐	Carpal Tunnel Syndrome	☐	☐	Blood Clotting Problems
☐	☐	Diarrhea	☐	☐	Hip Problems	☐	☐	Blood Clots
☐	☐	Constipation	☐	☐	Knee Pain/Problems	☐	☐	Bruise Easily
☐	☐	Black/Bloody Stools	☐	☐	Ankle/Foot Pain	☐	☐	Phlebitis
☐	☐	Abdominal Pain/Cramps	☐	☐	Joint Stiffness			**Allergic/Immunologic**
☐	☐	Liver Problems	☐	☐	Joint Swelling	☐	☐	Season/Environmental
☐	☐	Gall Bladder Problems	☐	☐	Muscle Pain or Cramps	☐	☐	Food Sensitivities
☐	☐	Weight Concerns	☐	☐	Muscle Weakness	☐	☐	Severe Allergic Reaction
☐	☐	Gas/Bloating after Meals	☐	☐	Difficulty Walking	☐	☐	Auto Immune Disorder
☐	☐	Inflammatory Bowel Disease	☐	☐	Jaw Pain/Clicking Jaw	☐	☐	Immune Deficiency
			☐	☐	Loss of Muscle Control	☐	☐	Recurrent Infections

Check any of the following conditions you have or have had:

☐ Alcohol/Drug Dependence	☐ Congenital Birth Defect	☐ Measles	☐ Scarlet Fever
☐ Allergies	☐ Diabetes	☐ Miscarriage	☐ Scoliosis
☐ Anemia	☐ Eczema	☐ Mononucleosis	☐ Stroke
☐ Appendicitis	☐ Emphysema	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Arteriosclerosis	☐ Epilepsy	☐ Mumps	☐ Tuberculosis
☐ Arthritis	☐ Goiter	☐ Parkinson's	☐ Ulcers
☐ Asthma	☐ Gout	☐ Pneumonia	☐ Venereal Disease
☐ Cancer	☐ Heart Disease	☐ Polio	☐ Other: _____
☐ Chicken Pox	☐ HIV/AIDs	☐ Rheumatoid Arthritis	
☐ Cold Sores	☐ Lupus	☐ Rheumatic Fever	

FAMILY HEALTH INFORMATION – Please indicate if any family members have or had any diseases. Many health problems are hereditary, thus information about your family members will give us a better picture of your total health.

Father: _____ Mother: _____

Siblings: _____ Children: _____

Maternal Grandparents: _____ Paternal Grandparents: _____

PERSONAL LIFESTYLE HABITS –	Heavy	Moderate	Light	None
Caffeine	☐	☐	☐	☐
Alcohol Consumption	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Sleep (hours/night): _____

Do you feel you eat healthy? ☐ Yes ☐ No

Do you think you need vitamins? ☐ Yes ☐ No

I hereby acknowledge the above information is true and accurate. I hereby authorize the Doctor to treat my condition as he or she deems appropriate.

_____ _____ _____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**