

PATIENT HEALTH QUESTIONNAIRE  
AMERICAN CHIROPRACTIC HEALTH

**PERSONAL INFORMATION**

Today's Date: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Preferred First Name / Nickname: \_\_\_\_\_  
Are you:  right handed  left handed  ambidextrous Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_ OK to call at work?  Yes  No  
Email: \_\_\_\_\_

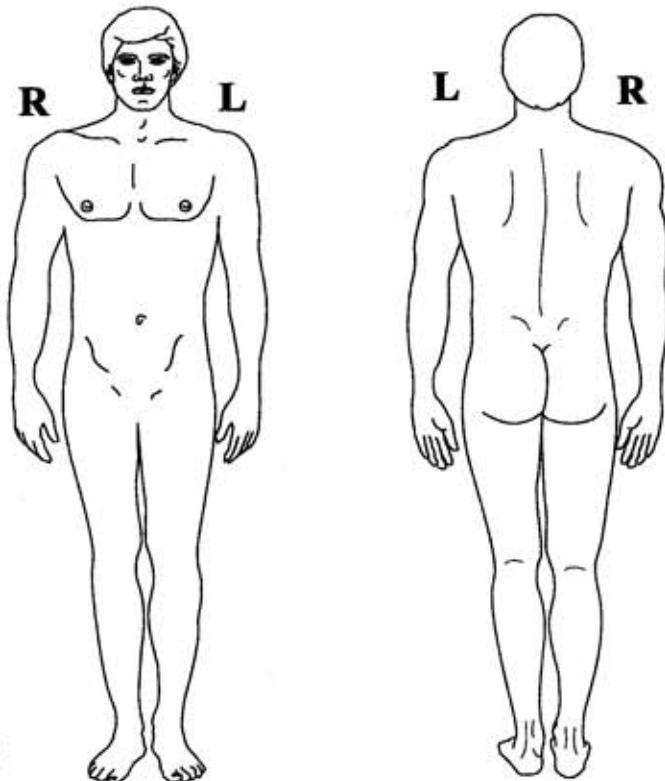
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Who Referred You To Our Office Or How Did You Hear About Us? \_\_\_\_\_  
Have You Had Previous Chiropractic Care?  No  Yes; if so please indicate when and the doctors name: \_\_\_\_\_

Date of Your Last Physical Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CURRENT COMPLAINTS**

**Pain Drawing:** Please mark where and what type of pain you are currently experiencing. Use the symbols indicated to describe the type of pain or sensations you are feeling:



Use these symbols to describe the type of pain or sensations you are feeling:

- >>> Aching pain
- /// Stabbing or Sharp pain
- XXX Burning pain
- == Numbness
- ooo Pins and Needles

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Please list your complaints below with the most significant or primary complaint first:

1. **Area of Pain:** \_\_\_\_\_ **Frequency:**  intermittent  occasional  frequent  constant  
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

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

The pain is aggravated by: \_\_\_\_\_

The pain is relieved by: \_\_\_\_\_

2. **Area of Pain:** \_\_\_\_\_ **Frequency:**  intermittent  occasional  frequent  constant  
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

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

The pain is aggravated by: \_\_\_\_\_

The pain is relieved by: \_\_\_\_\_

3. **Area of Pain:** \_\_\_\_\_ **Frequency:**  intermittent  occasional  frequent  constant  
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

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

The pain is aggravated by: \_\_\_\_\_

The pain is relieved by: \_\_\_\_\_

4. Other: \_\_\_\_\_

In general my symptoms are worse in:  AM  Midday  PM;  my symptoms do not change with the time of day.

Are your symptoms / condition:  improving  unchanged  getting worse

***HISTORY***

Symptoms developed from:  work injury  car accident  sports injury  lifting/fall  gradual  unknown

The pain began on or about: \_\_\_\_\_ The pain is chronic and originally began on or about: \_\_\_\_\_

Describe how the symptoms began or what you think caused the symptoms / condition: \_\_\_\_\_

List other doctors you have seen for this complaint, the type of treatment given, and the result of that treatment: \_\_\_\_\_

Describe any past history of the same or similar complaint: \_\_\_\_\_

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**MEDICAL HISTORY**

CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Blurring vision  | <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Headaches: Area of head: _____                                      |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Numbness                   | How often: <input type="checkbox"/> daily <input type="checkbox"/> _____ times per day       |
| <input type="checkbox"/> Loss of bowel or bladder function                        | <input type="checkbox"/> Confusion                  | <input type="checkbox"/> _____ times per week <input type="checkbox"/> _____ times per month |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Loss of sleep              | <input type="checkbox"/> Chest pains   |
| <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Stomach difficulty         | <input type="checkbox"/> Painful urination   |
| <input type="checkbox"/> Rectal bleeding  | <input type="checkbox"/> Frequent urination         | <input type="checkbox"/> Difficulty swallowing   |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Frequent colds             | <input type="checkbox"/> Hay fever   |
| Do you have a pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Asthma                     |  |

Please list any serious illness or medical conditions you have had and associated treatment:

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Please list the name and address of your primary care physician & any specialist you have seen:

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**SURGICAL HISTORY**

Please list any surgeries you have had; include date, type of surgery or for what condition and outcome:

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**FAMILY HISTORY**

Please list any family history of heart disease, cancer, diabetes or other serious illness:

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**Women Only**

**Important - if you suspect you are currently pregnant, please notify the doctor immediately.**

**X-rays should not be taken if you are pregnant!**

Are you pregnant?  Yes  No Date of last menstrual cycle: \_\_\_\_\_ Do you have PMS?  Yes  No

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**WORK HISTORY**

How many hours do you normally work in a week? \_\_\_\_\_ Are you currently not working?  Yes  No

In a typical workday, I: (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

On the job, I perform the following activities:

In terms of an 8-hour workday, "occasionally" = 33%, "frequently" = 34% to 66%, and "continuously" = 67% to 100% of the day.

	Not At All	Occasionally	Frequently	Continuously
Bend / Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check the category that best describes your work:

- Sedentary:** Lifting up to 10 lbs. maximum and occasionally lifting and / or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking is required only occasionally and other sedentary criteria are met.
- Light Work:** Lifting 20 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 10 lbs. Even though the weight lifting may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling or arm and / or leg controls.
- Medium Work:** Lifting 50 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 25 lbs.
- Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 50 lbs.
- Very Heavy Work:** Lifting objects in excess of 100 lbs. with frequent lifting and / or carrying of objects weighing 50 lbs. or more.

**SOCIAL HISTORY**

Do you smoke?  No  Yes; if yes, how many packs of cigarettes do you smoke per day? \_\_\_\_\_

How many cups of coffee or caffeinated drinks do you have per day? \_\_\_\_\_

Do you consume alcohol?  No  Yes; if yes, would you say that your use of alcohol is  occasional  frequent or  daily.

Would you say your consumption of alcohol is  light,  medium, or  heavy?

Do you have a regular program of exercise?  No  Yes, if yes, please note the frequency and type of exercise that you do:

\_\_\_\_\_

\_\_\_\_\_

List any hobbies or recreational sports / activities you enjoy doing:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(or guardian if child)