Advanced Chiropractic of Mankato — Patient Health Questionnaire

Name: _____ Birth Date: ___/___/____

Address: _____ Phone: _____

City, State, Zip: _____ Soc. Sec#: _____

1. Please Describe Your Complaint: _____

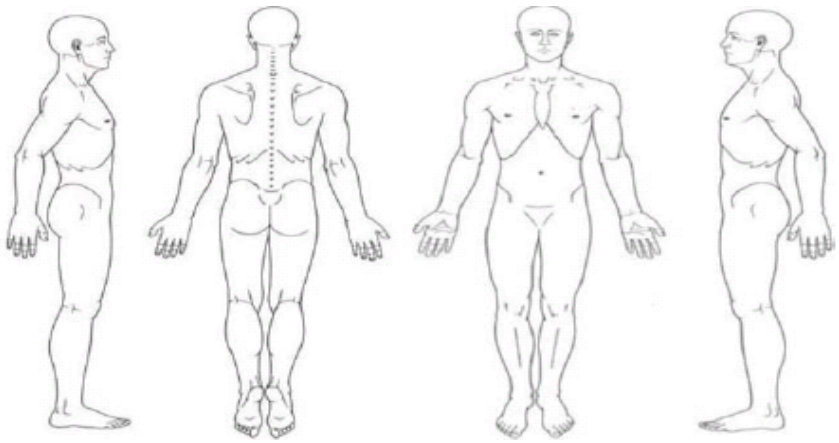
_____

_____

a. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

Mark on the picture where you have pain or other symptoms



c. Indicate the intensity of your pain at its lowest and highest level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

d. Your symptoms are: ☐ decreasing ☐ not changing ☐ increasing

e. Your symptoms are worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Increases during the day ☐ Same all day

2. When did your problem begin (specific date if possible)? _____
Describe how your problem began: _____

_____

3. Have you been treated for this episode? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical therapist ☐ Occupational therapist ☐ Other: _____
Are you currently being seen? ☐ Yes ☐ No
When and what treatment? ___/___/___ _____

_____

4. In the past have you been treated for the same or similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical therapist ☐ Occupational therapist ☐ Other
When and what treatment? ___/___/___ _____

_____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

7. How would you rate your general stress level? ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

8. General physical activity? ☐ No Regular Exercise ☐ Light Exercise ☐ Moderate Exercise ☐ Strenuous Exercise

9. Are your complaints affecting your ability to be active?
- ☐ No Effect
- ☐ Some physical restrictions (able to perform light duty work and household tasks)
- ☐ Need limited assistance with common everyday tasks
- ☐ Need assistance often
- ☐ Have a significant inability to function without assistance
- ☐ Am totally disabled (impaired). Cannot care for self.

10. Physical activity at work: ☐ Sitting more than 50% of day ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion

11. Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No

Patient's Signature: _____ Date: _____/_____/_____

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Past	Present	
□	□	Neck Pain
□	□	Shoulder Pain
□	□	Pain in upper arm or elbow
□	□	Hand Pain
□	□	Wrist Pain
□	□	Upper Back Pain
□	□	Lower Back Pain
□	□	Pain in upper leg or hip
□	□	Pain in lower leg or knee
□	□	Pain in ankle or foot
□	□	Jaw Pain
□	□	Swelling/Stiffness of joints
□	□	Fainting
□	□	Visual disturbances
□	□	Convulsions
□	□	Dizziness
□	□	Headache
□	□	Muscular incoordination
□	□	Tinnitus
□	□	Rapid Heart Beat
□	□	Chest Pains
□	□	Loss of Appetite
□	□	Abnormal weight □ Gain □ Loss
□	□	Excessive thirst
□	□	Chronic cough
□	□	Chronic sinusitis
□	□	General fatigue
□	□	Irregular Menstrual flow
□	□	Profuse Menstrual flow
□	□	Breast soreness/lumps
□	□	Endometriosis
□	□	PMS
□	□	Loss of Bladder Control
□	□	Painful Urination
□	□	Frequent Urination
□	□	Abdominal Pain
□	□	Constipation/Irregular Bowel Habits
□	□	Difficulty swallowing
□	□	Heartburn/Indigestion
□	□	Dermatitis/Eczema/Rash
□	□	Depression

Past	Present	
□	□	Pregnancy
□	□	Birth Control Pills
□	□	Hormonal/ Estrogen Replacement
□	□	Medications _____ _____
□	□	Hospitalizations/Surgical procedures _____

Past	Present	
□	□	Aortic Aneurysm
□	□	High Blood Pressure
□	□	Angina
□	□	Heart Attack
□	□	Stroke
□	□	Asthma
□	□	Cancer
□	□	Tumor
□	□	Prostate Problems
□	□	Blood Disorders
□	□	Emphysema (chronic lung disorders)
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	Diabetes
□	□	Epilepsy
□	□	Ulcer
□	□	Liver/ Gallbladder problems
□	□	Hepatitis
□	□	Kidney Stones
□	□	Bladder Infection
□	□	Kidney Disorders
□	□	Colitis
□	□	Irritable Bowel
□	□	HIV/AIDS
□	□	Systemic Lupus
□	□	Other: _____

If a family member has had any of the following please make the appropriate box

□ Cancer	□ Epilepsy
□ Rheumatoid Arthritis	□ Chronic Back problems
□ Diabetes	□ Chronic headaches
□ Heart Problems	□ Lupus
□ Lung Problems	□ Other: _____
□ High Blood Pressure	_____

Yes	No	
□	□	Do you have a permanent disability rating?
□	□	Location? _____
□	□	Date rating received ___/___/___
		Rating percentage _____%

Past	Present	
□	□	Tobacco
□	□	Alcohol
□	□	Drug/Alcohol dependence
□	□	Coffee/Tea/Caffeinated soft drinks
		Cups per day: _____

Present Weight _____ lbs. Height ___feet ___ inches

Patient's Signature: _____ Date: ____/____/____

Additional Doctor Comments: