Patient Health Questionnaire

Patient Name:______________________________________ **DOB**:___/____/_____ **Date of Visit:**___/___/____

General Information

Race ☐Caucasian ☐African American ☐Asian ☐Hispanic ☐Native American ☐Other

What is your occupation? ____

What is your employment status? ☐Full time ☐Part time ☐Unemployed ☐Retired ☐Sick Leave ☐Disability

Who is your Primary Doctor? ____________________________ **What Clinic?** _____________________________

Do you use tobacco? ☐Current daily smoker ☐Occasional smoker ☐Former smoker ☐Never smoked

Do you consume alcohol? ☐Never ☐Rare ☐Occasional **If yes, how often?** ____________________________

Are you pregnant? ☐Yes ☐No ☐N/A **If yes, when is your due date?** ___________________________________

Current Issue/Ailment

What is your chief problem or symptom? ____

What caused the problem to occur? ____

When did the problem/symptom begin? (Date of Injury) ____

Have you seen another doctor for this problem? ☐Yes ☐No

What tests and procedures have been performed? ____

Have you had this problem/symptom in the past? ☐Yes ☐No **Have you tried any other treatments?** ☐Yes ☐No

Has the problem/symptom changed? ☐Getting worse ☐Staying same ☐Improving

Pain/Symptom Evaluation

Describe your pain/symptoms (check all that apply)

Please rate your current discomfort level (Circle) (1=mild, 10= intense) 1 2 3 4 5 6 7 8 9 10

How much has it interfered with your normal work? ☐Not at all ☐A little bit ☐Moderately ☐Extremely

In general, how would you describe your overall health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

What, if anything, gives you relief? ____

What irritates it or makes it worse? ____

Frequency	**Quality**		**Pattern**	**Cause**
☐Constant	☐Aching	☐Stiff	☐While resting	☐Trauma/Injury
☐Rare	☐Dull	☐Sore	☐Daily	☐Chronic
☐Comes and Goes	☐Sharp	☐Pressure	☐During Activity	☐Post-Surgical
☐Recurring	☐Shooting	☐Pulling	☐Nightly	☐Work Related
☐Frequent	☐Burning	☐Pinching	☐Other: _______________	☐Motor Vehicle Accident
	☐Numbness	☐Weakness		☐School Sports
	☐Tingling	☐Dizziness		☐Unknown
	☐Tight	☐Throbbing		☐Other: ________________

Please Proceed to the Backside of this Document

Allergies

Please list any allergies below:

☐ **No allergies (medications, latex, iodine, etc.)**

Medications

Please list medication name and amount below: (if it is more than 6 medications, please provide us with a separate list)

Medication	**Type** (blood pressure, cholesterol, diabetes, etc.)

☐ **No Medications**

Severe Accidents/Trauma/Surgical History

Severe Accidents/Trauma		**Surgeries**	
Accident/Trauma Details	**Date**	**Type of Surgery**	**Date**

☐ **No History of Accidents/Trauma/Surgery**

Medical History

Current or past conditions/ailments - check all that apply:

☐Stroke
☐Diabetes
☐Heart disease/attack
☐Cancer
☐Hepatitis B/Hepatitis C
☐HIV/AIDS
☐High Cholesterol
☐Chest Pain/Shortness of breath
☐Headaches
☐Dizziness
☐Seizures
☐Emphysema/COPD
☐Asthma/Bronchitis
☐Broken Bones
☐Concussion
☐Arthritis/Gout
☐Neuropathy
☐Depression/Anxiety
☐Chronic Fatigue
☐Thyroid Problems
☐Irregular Heartbeat
☐Digestive Problems
☐Difficulty Swallowing
☐Ringing in Ears
☐Eye Pain/Strain
☐Jaw Pain
☐Pregnancy
☐Female Disorders
☐Urinary Problems

☐**None of these apply to me**

Family History

Mother	**Father**	**Brothers**	**Sisters**
☐Living ☐Deceased	☐Living ☐Deceased	☐Living ☐Deceased	☐Living ☐Deceased
If deceased, how old? ______	If deceased, how old? ______	If deceased, how old? ______	If deceased, how old? ______
☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease
☐Stroke or Heart Attack	☐Stroke or Heart Attack	☐Stroke or Heart Attack	☐Stroke or Heart Attack
☐Cancer -Type_____________	☐Cancer -Type_____________	☐Cancer -Type_____________	☐Cancer -Type_____________
☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes
☐Other:__________________	☐Other:__________________	☐Other:__________________	☐Other:__________________

☐ **No Family History**