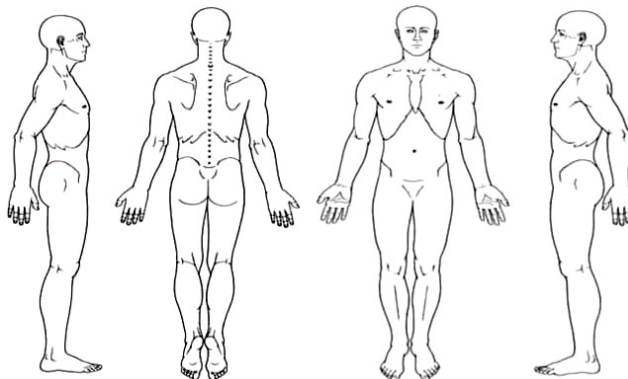


PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ Right / Left Handed

Please place an "X" to indicate current areas of pain on the body chart below:



Have you ever had the problem(s) before? **Y / N** When? _____

Have you had physical therapy, chiropractic, or other treatment for this problem? **Y / N** When? _____

Have you had x-rays, MRIs, or other special tests performed for your current problem? **Y / N**

Please give dates and results.

Within the past year, have you had any of the following symptoms? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bladder/bowel problems |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Unexplained weight loss/gain |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Joint Pain or swelling | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other: _____ |

Are you currently pregnant? **Y / N** Do you have allergies/**latex sensitivity**? _____

Medical History (check conditions you have or have had in the past)

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low blood sugar/hypoglycemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Head injury | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> HIV+ |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Other infectious disease |
| <input type="checkbox"/> Heart Problems/pacemaker | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure/epilepsy | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Developmental/growth problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Other: _____ |

List all past surgeries (month/year) _____

List all medications you are currently taking _____

Patient Signature: _____ **Date:** _____