PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ Date_____

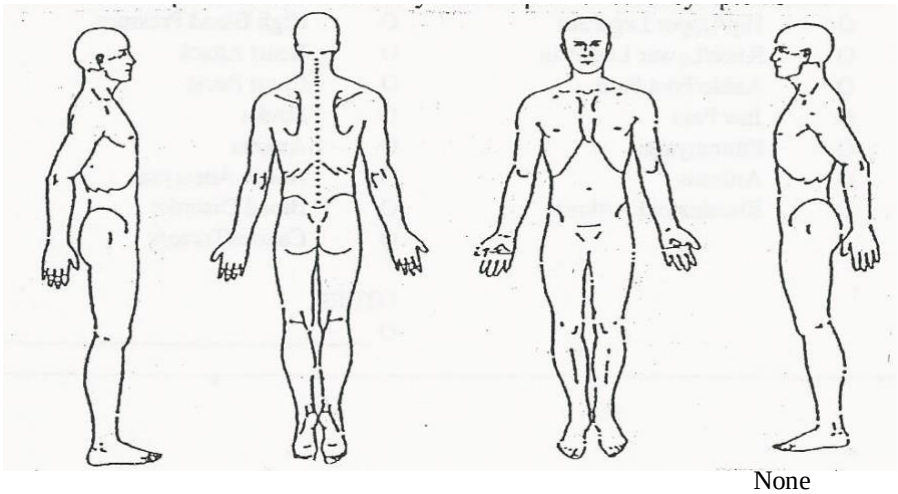
When did your symptoms start?_____

Describe your symptoms and how they began: _____

_____

_____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

O Constantly (76-100% of the day)
O Frequently (51-75% of the day)
O Occasionally (26-50% of the day)
O Intermittently (0-25% of the day)

What describes the nature of your symptoms?

O Sharp O Shooting
O Dull ache O Burning
O Numb O Tingling

How are your symptoms changing?

O Getting Better
O Not Changing
O Getting Worse

What is the intensity of your symptoms at their :

	None									Unbearable
Worst	1	2	3	4	5	6	7	8	9	10
Best	1	2	3	4	5	6	7	8	9	10

Who have you seen for this episode of your symptoms?
O No one O Medical Doctor O Massage
O Other Chiropractor O Physical Therapist O Other

When and what treatment was rendered?_____

Have you had same or similar symptoms in the past? O Yes O No

If you have received treatment in the past for the same or similar symptoms, who did you see?
O This office O Medical Doctor O Other
O Other Chiropractor O Physical Therapist

What tests have you had for your symptoms? O X-rays O CT scan O MRI O Other

What is your occupation?
O Professional/Executive O Labourer O Retired
O White Collar/Secretarial O Homemaker O Other
O Tradesperson O Student

If you are not retired, a homemaker, or a student, what is your current work status?
O Full time O Unemployed O O On disability
O Part time O Self-employed O Other

How is most of your day spent?
O Sitting OWalking
O Standing O Other (specify)_____

As a result of your symptoms, are you restricted in your ability to perform work and/or daily activities? O Yes O No

If yes, describe your restrictions: _____

OVER→

Do you currently wear custom foot orthotics? YES NO

Please list all prescription and over-the-counter medications you are taking.

_____ _____ _____ _____

Have you ever had to take a medication for a prolonged period of time? YES (specify)_____ NO

Please list all major surgical procedures. Please include approximate dates.

_____ _____

_____

For each of the conditions below, place a check in the column if you have had it in the past or are currently experiencing that condition. If a condition is not listed below, please write it in under OTHER.

O Headaches

O Neck Pain
O Upper Back Pain
O Mid Back Pain
O Low Back Pain
O Shoulder Pain
O Elbow/Upper Arm Pain
O Wrist/Hand Pain

O Jaw Pain

O Hip/Upper Leg pain
O Knee/Lower Leg Pain
O Ankle/Foot Pain
O Fibromyalgia
O Arthritis
O Rheumatoid Arthritis

OTHER_____

O High Blood Pressure
O Heart Attack
O Chest Pains
O Stroke
O Angina
O Aortic Aneurysm
O Blood Disorder
O Cancer/Tumors

_____