atient Name						
When did your	symptoms start:					
① Constantly (② Frequently (③ Occasionally ④ Intermittently ③ What describe ① Sharp ② Dull ache ④ Numb	you experience your symptoms? 76-100% of the day) 51-75% of the day) y (26-50% of the day) y (0-25% of the day) es the nature of your symptoms? ④ Shooting ⑤ Burning ⑥ Tingling symptoms changing?	Indicate where you have pa	ain or other symptoms			
① Getting Bett② Not Changing③ Getting Work	ng			Unbearable		
5. How had are y		0,00	(4) (5) (6) (7) (8) (4) (5) (6) (7) (8)	9 P		
⊚ (i No complaints	symptoms affect your ability to per	⑤ ⑥ ⑥ feres Limiting, prevents	(1) (1) (1) (2) (3) (4) (4) (5) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	® Severe, no activity possible		
3. What activitie	s make your symptoms better:			-		
). Who have you	ı seen for your symptoms?	① No One② Other Chiropractor	Medical DoctorPhysical Therapist	⑤ Other		
a. When and	l what treatment?					
h. What tests and when we	s have you had for your symptoms ere they performed?	① Xrays date: ② MRI date:				
10. Have you ha	d similar symptoms in the past?	① Yes ② No				
	e received treatment in the past for similar symptoms, who did you see?	① This Office ② Other Chiropractor	 Medical Doctor Physical Therapist	⑤ Other		
11. What is your	coccupation?	① Professional/Executive② White Collar/Secretarial③ Tradesperson	4 Laborer5 Homemaker6 FT Student	 Retired Other		
	not retired, a homemaker, or a at is your current work status?	① Full-time ② Part-time	Self-employedUnemployed	<a>® Off work <a>® Other		
12. What do you ⊕ Reduce sym ② Resume/inc			⑤ How to prevent this from⑥	n occurring again		
Patient Signatur	9		Data			

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American Chiropractic Network

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Patier	nt Name	-		Date _		
What type of regular exercise do you perform?			① None	2 Light	③ Moderate	
What is your height and weight?			Height Feet	Inches	Weight	lbs.
For e If you	ach of the conditions listed belo presently have a condition liste	w, place a	a check in the Past colum place a check in the Pres	n if you ha ent colum	ave had the conc n.	lition in the past.
	Present	Past I			ast Present	
0	O Headaches	0	O High Blood Pressure	(O Diabetes	3
0	O Neck Pain	0	O Heart Attack	(O Excessiv	
0	O Upper Back Pain	0	O Chest Pains	(○ Frequen	t Urination
0	O Mid Back Pain	0	○ Stroke			
0	○ Low Back Pain	0	○ Angina	(/Use Tobacco Products
0	O Shoulder Pain	0	O Kidney Stones	7	O Drug/Alc	ohol Dependence
0	Elbow/Upper Arm Pain	0	Kidney Disorders	(○ ○ Allergies	
0	O Wrist Pain	0	Bladder Infection		O Depress	
0	O Hand Pain	0	O Painful Urination		Systemic	
		0	O Loss of Bladder Control		Epilepsy	
0	O Hip/Upper Leg Pain	0	O Prostate Problems			is/Eczema/Rash
0	○ Knee/Lower Leg Pain	0			O O HIV/AID	
0	○ Ankle/Foot Pain	0	O Abnormal Weight Gain/			
\circ	○ Jaw Pain	0	O Loss of Appetite	1	Females Only	
\circ	0 1-1-1 0 11 1017	0	Abdominal Pain		○ ○ Birth Cor	ntrol Pills
0	O Joint Swelling/Stiffness	0	○ Ulcer	(Hormona	al Replacement
	O Arthritis	0	○ Hepatitis		○ Pregnan	су
0	O Rheumatoid Arthritis	0	O Liver/Gall Bladder Diso	rder	0 0	
0	○ General Fatigue	0	○ Cancer	(Other Health Pro	hlems/Issues
0	 Muscular Incoordination 	0	○ Tumor		0 0	210/110/100400
0	 Visual Disturbances 	0	O Asthma		0 0	
0	O Dizziness	0	O Chronic Sinusitis		0 0	
Indicate if an immediate family member has had any of the following: O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O						4a kin an
List al	I the surgical procedures you ha	ve had a	nd times you have been h	ospitalize	d:	
					•	
Patient Signature				Da	ate	
Docto	r's Additional Comments					
Doctors Signature				Da	ate	