PATIENT'S PRESENT COMPLAINTS

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Social Security# _____ Height _____ Weight _____

Age _____ Birthdate ____/____/____ Sex M / F Status M S W D No. Children _____

Occupation _____ Employer _____ Wk Ph. _____ Years Employed ____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____ Soc. Sec.# _____

Person Responsible for this Account _____

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)? _____

PLEASE DESCRIBE YOUR CURRENT PROBLEM. _____

_____

HOW DID YOUR PROBLEM BEGIN? _____

DATE PROBLEM BEGAN: ____/____/____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION IN THE PAST? (SURGERY, MEDICATIONS, INJECTIONS, THERAPY, CHIROPRACTIC) _____

_____

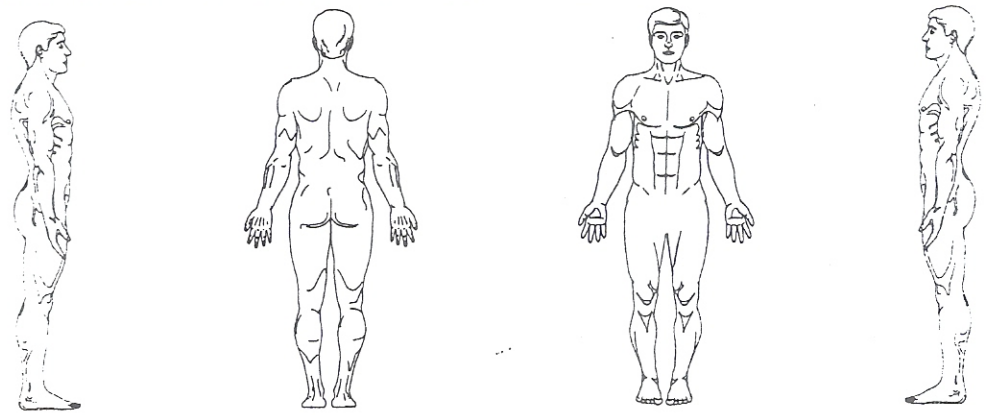
HAVE YOU HAD X-RAYS, MRI OR OTHER TESTS FOR THIS CONDITION? WHAT TESTS AND WHEN? _____

_____

How bad is your pain? (Circle a number) 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

How often are your symptoms present?	☐ Constantly	☐ Frequently	☐ Occasionally ☐ Intermittently
Describe your current pain/symptoms:	☐ Sharp/Stabbing ☐ Dull ☐ Numbness ☐ Burning	☐ Throbbing ☐ Soreness ☐ Shooting ☐ Tingling	☐ Aches ☐ Weakness ☐ Gripping ☐ Other _____
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/rest	☐ Walking ☐ Movement ☐ Other _____
What makes the problem worse?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/rest	☐ Walking ☐ Movement ☐ Other _____
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: _____ Date: _____

Patient Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	General Fatigue	○	○	Cancer	***Other Health Problems/Issues***		
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Provider's Additional Comments

_____

_____

_____