Calvert City CHIROPRACTIC

5131 U.S. Highway 62 • Calvert City, Kentucky 42029 • Office Phone (270) 395-4540 • Fax (270) 395-7715

Bradley A. Tack, D.C.
Lisa A. Tack, D.C.

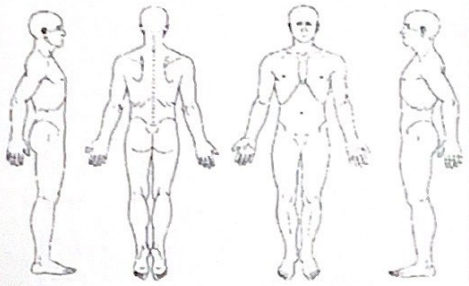
Patient Health Questionnaire

Patient Name _____ **Date** _____

Patient Fill Out: 1 - 12

1. **When did your symptoms start?** _____
   Describe your symptoms and how they began: _____

2. **How often do you experience your symptoms? Circle where you have pain or other symptoms.**
   ① Constantly (76 - 100% of the day)
   ② Frequently (51 - 75% of the day)
   ③ Occasionally (26 - 50% of the day)
   ④ Intermittently (0 - 25% of the day)



3. **What describes the nature of your symptoms?**
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

4. **How are your symptoms changing?**
   ① Getting Better ② Not Changing ③ Getting Worse

5. **How bad are your symptoms at their:**

	None										Unbearable
a. worst	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. **How do your symptoms affect your ability to perform daily activities?**

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints	Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible	

7. **What activities make your symptoms worse?** _____
8. **What activities make your symptoms better?** _____
9. **Who have you seen for your symptoms?** ① No One ③ Medical Doctor ⑤ Other ② Other Chiropractor ④ Physical Therapist
   a. When and what treatment? _____
   b. What tests have you had for your symptoms and when were they performed?
      ① X-rays date: _____ ③ CT Scan date: _____
      ② MRI date: _____ ④ Other date: _____
10. **Have you had similar symptoms in the past?** ① Yes ② No
    a. If you have received treatment in the past for the same or similar symptoms, who did you see?
       ① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other
11. **What is your occupation?** _____
    ① Professional / Executive ③ Tradesperson ⑤ Homemaker ⑦ Retired
    ② White Collar / Secretarial ④ Laborer ⑥ FT Student ⑧ Other
    a. If you are not retired, a homemaker, or a student, what is your current work status?
       ① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other
12. **What do you hope to get from your visit / treatment** *(select all that apply)*:
    ① Reduce Symptoms ④ Learn how to take care of this on my own
    ② Resume / increase activity ⑤ How to prevent this from occurring again
    ③ Explanation of condition / treatment ⑥ _____

Doctor's Notes:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Patient Signature _____ **Date** _____ **Drs. Initials** _____ **Date** _____

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Patient Health Questionnaire - page 2

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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 [ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

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
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	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 _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ Date _____