

Patient Health Questionnaire

Name: _____ **Age:** _____ **Weight:** _____ **Height:** _____

Occupation: _____

Are you currently experiencing or do you have any of the following:

Conditions

- High Blood Pressure Yes No
- Pacemaker Yes No
- Spinal cord stimulator Yes No
- Stroke/TIA Yes No
- Lung Disease/COPD Yes No
- Blood clots Yes No
- Blood thinners Yes No
- Osteoporosis Yes No
- Osteoarthritis Yes No
- Rheumatoid Arthritis Yes No
- Autoimmune Disease Yes No
- Diabetes Yes No
- Kidney Disease Yes No
- Thyroid Disease Yes No
- Stomach Ulcers Yes No
- Hepatitis Yes No

Type: _____

Cancer Yes No

Site: _____

Pregnancy Yes No

Asthma Yes No

HIV Yes No

Symptoms

- Dizziness Yes No
- Visual disturbances Yes No
- Ringing in ears Yes No
- Hearing loss Yes No
- Nausea/vomiting Yes No
- Headache Yes No
- Difficulty swallowing Yes No
- Unexplained weight changes Yes No
- Pain wakes me at night Yes No
- Chest pain Yes No
- Cough Yes No
- Shortness of breath Yes No
- Bowel or bladder disorder Yes No
- Recent fever, chills, sweats Yes No
- Depression Yes No

Social History/Wellness

Do you drink alcoholic beverages? Yes No

Do you use tobacco? Yes No

Do you exercise regularly? Yes No

Other medical illness: (Please list): _____

List current medications (include prescription, over-the-counter, and herbal): _____

List any known allergies (include medications, latex, etc): _____

List the dates and results of any X-rays: _____

MRI: _____

Bone Density test: _____

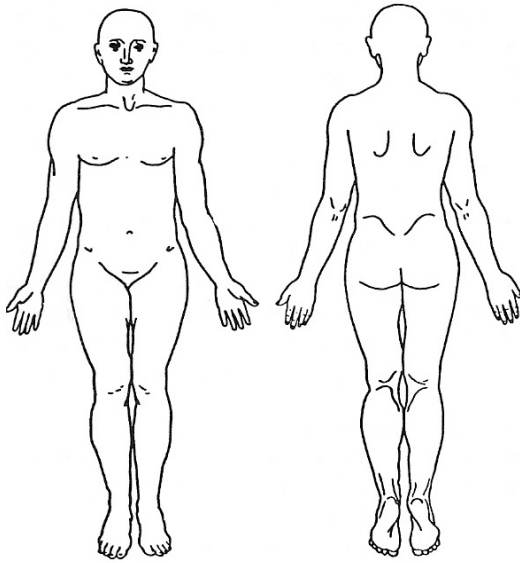
Nerve Conduction test: _____

Other: _____

List of previous hospitalizations/surgeries with approximate dates: _____

History of Current Problem or Symptom

Please mark on the diagram below to indicate where you feel symptoms. Use the following key to indicate the different types of symptoms.



- Deep Ache = ZZZZ
- Sharp/Stabbing = ///
- Pins and needles = 0000
- Burning = XXXX
- Throbbing = ++++

Do you have any regular numbness, tingling, or burning? Yes No If yes, where? _____

Please describe in detail your current problem and how this problem began: _____

When did this problem first begin? (Approximate date): ____/____/____

Have you ever had this problem before? Yes No

If you have, what treatment helped the most? _____

My pain/problem is slowly getting worse better staying the same

My symptoms bother me: constantly 100% most of the time 75% occasionally 50% once in a while 25% or less

Are your symptoms worse in: Morning Afternoon Evening Night Same all day

What worsens your symptoms? _____

What makes your symptoms better? _____

On a scale from 0-10 (0 = no pain; 10 = worst pain imaginable), what is the **worst** your pain has been in the past several days? ____/10. What is the **best** your pain has been? ____/10.

Please rate your **current** pain on the line below.

0.....5.....10

How are you able to sleep at night? (Check one)

- Fine
- Moderate difficulty
- Only with medication
- Change positions all night

PATIENT'S SIGNATURE: _____ DATE: ____/____/____