timothy
santo, dc
chiropractor

PATIENT HEALTH QUESTIONNAIRE

Welcome to our office!

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Contact Phone _____ Email _____

Age _____ Birthdate _____ Sex _____ Marital Status _____ Children _____

Occupation _____ Referred by _____

If you are not retired, a homemaker or a student, what is your current work status? _____

Describe your symptoms: _____

_____

When did your symptoms start? _____

HOW did your symptoms begin (i.e., Auto, Trip, Fall, Posture, Unknown, Other) and **WHEN** did they begin?

_____

_____

Have you ever experienced this problem before? Y ___ N ___ If yes, when: _____

_____

How often do you experience your 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)

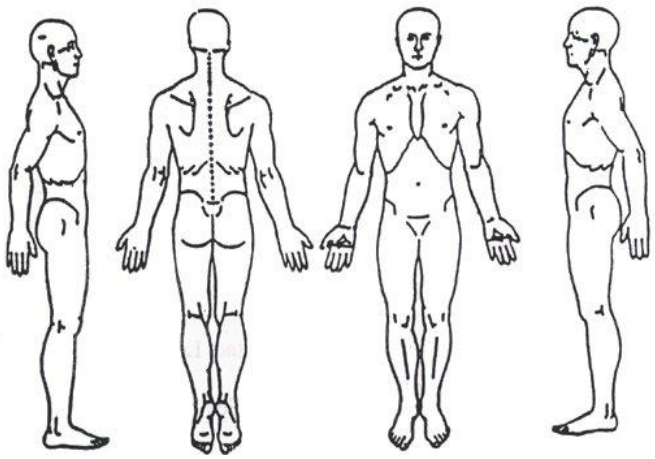
What describes the nature of your symptoms?

5 Sharp 8 Shooting
6 Dull ache 9 Burning
7 Numb 10 Tingling

How are your symptoms changing?

11 Getting better
12 Not Changing
13 Getting Worse

Indicate where you have pain or other symptoms:



What is the severity of the above-mentioned problems?

Mild 1 2 3 4 5 6 7 8 9 10 Severe

Relieving Factors: ___ Rest ___ Exercise ___ Bracing ___Sitting ___ Standing ___Lying ___Heat ___ Ice ____ Baths

Other: _____

Aggravating Factors: ___ Coughing ___ Sneezing ___ Lifting ___ Bending ___ Sitting ___Reaching ___Standing

____ Walking ____ Running ____ Driving ____ Pushing ____Other: _____

Patient Name _____ Date _____

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	○	○	Smoking/Use Tobacco Product
○	○	Low Back Pain	○	○	Angina	○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Allergies
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Depression
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Systemic Lupus
○	○	Hand Pain	○	○	Painful Urination	○	○	Epilepsy
			○	○	Loss of Bladder Control			
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain	○	○	Abnormal Weight Gain/Loss	○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Loss of Appetite	○	○	Ulcer
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Hepatitis
○	○	Joint Swelling/Stiffness	○	○	Liver/Gall Bladder Disorder	○	○	Cancer
○	○	Arthritis	○	○	Tumor	**FEMALES ONLY**		
○	○	Rheumatoid Arthritis	○	○	Asthma	○	○	Birth Control Pills
○	○	General Fatigue	○	○	Chronic Sinusitis	○	○	Hormonal Replacement
○	○	Muscular Incoordination	○	○	Dizziness	○	○	Pregnancy
○	○	Visual Disturbances				○	○	Menstrual Issues

Additional information regarding the above: _____

_____

Indicate if an immediate family member has had any of the following:
___Rheumatoid Arthritis ___ Heart Problems ___ Diabetes ___ Cancer ___ Lupus ___Other: _____

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: _____

_____

_____

Name of Insurance Company _____ Policy No. _____
Address _____

Patient Signature: _____ Date: _____

Doctor's Additional Comments:

_____

_____

_____

Doctor's Signature: _____ Date _____