PLEASE BRING WITH YOU or MAIL IN PRIOR TO YOUR CONSULTATION.THANK YOU

Patient Health Questionnaire

NAME: _____ **TODAY'S DATE:** _____

Describe your current primary complaint: _____

When was the onset of your pain? _____

Was it due to an injury? Yes No **Injury date:** _____

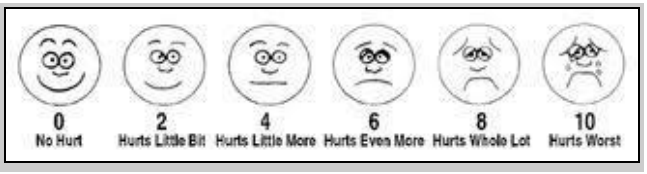
Least pain experienced in the last month on 0-10 scale: _____

Describe Least Pain (Please circle): DULL SHARP SQUEEZING OTHER: _____

Most pain experienced in the last month on 0-10 scale: _____

Describe Most Pain (Please circle): DULL SHARP SQUEEZING OTHER: _____

Pain Rating Scale-What is your pain level today?_____



Do you walk with a limp? Yes No **Favor a side?** Yes No – Right or Left

Pain increase with cough/sneeze? Yes No

Weakness? Yes No **Drag a foot or leg?** Yes No- Right or Left

Numbness and tingling? Yes No **If yes:** Constant or Intermittent

Where is it at? _____

Do you drop things? Yes No **With Which Hand?**

Hard to get to sleep? Yes No

Does pain wake you up at night? Yes No If yes: Constant Intermittent

How has pain modified your activities? _____

_____

What triggers the pain? _____

Have you tried:

Heat:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Ice:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Chiropractor:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Acupuncture:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Physical Therapy:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
TENS:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Surgery:	Yes ____No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Steroid Injection:	Yes ____ No ____	Did it Help?	Yes ____No ____	Date Last Used: _____
Massage:	Yes ____ No ____	Did it Help?	Yes ____No ____	Date Last Used: _____

IT IS VERY IMPORTANT THE FOLLOWING SECTION BE COMPLETED ACCURATELY SO WE DO NOT PRESCRIBE A PAST MEDICATION THAT HAS FAILED

Medications: Yes ____ No ____

- Medications Used:
  1. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  2. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  3. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  4. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  5. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  6. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  7. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  8. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  9. _____ Did it Help? Yes _____ No_____ Date Last Used:_____
  10. _____ Did it Help? Yes _____ No_____ Date Last Used:_____

What gives you pain relief? _____

What increases the pain? _____

Do you live: Alone With family Friends for support (rides)

Please circle who we may share your medical information with and their name(s) if indicated:

Spouse: _____, Father: _____,

Mother: _____, Other: _____,

Pt Only

Employment Status (circle one): working retired unemployed

If working, please list what physical activity your job includes:

_____

Health History Questionnaire and Physical

Patient Name_____ Date of Birth_____

Ht._____Wt._____Age._____

Please list any prescription and/or non-prescription medications you are currently taking, including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications.

Name of Medication, dose	Directions	Name of Medicine, dose	Directions

Have you taken steroid or cortisone-type drugs within the last year? Yes_____ No_____
Have you had a Bone Mineral Density Test? Yes_____ No_____ Do you exercise? Yes_____ No_____

Please list medications to which you had hives, skin rash, breathing problems or other allergic reactions.

Name of Medicine	Describe Allergic Reaction

List medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side-effects. _____.

Have you had an allergic reaction to:

Shellfish/Seafood	Yes_____ No_____	Feathers/Eggs	Yes_____ No____
Iodine or X-ray contrast dye	Yes_____ No_____	Latex or Rubber	Yes_____ No____
Bee or wasp stings	Yes_____ No_____	Adhesive tape	Yes_____ No____

List any food allergies or intolerances: _____
List any current special diet:_____

SURGICAL HISTORY

Have you or any family member had a complication related to anesthesia? Yes_____ No_____
Explain_____

Type of Surgery	Year Performed	Physician/Hospital

FAMILY HISTORY

Father: _____ Alive (Age_____) _____Deceased (Age_____) _____Unknown

Medical problems/Cause of Death: _____ Unknown_____

Mother: _____ Alive (Age_____) _____Deceased (Age_____) _____Unknown

Medical problems/Cause of Death: _____ Unknown_____

REVIEW OF SYSTEMS PATIENT'S NAME_____ DOB_____

Do you have or have you had:

Any problems with **Heart or Circulation**?

Heart Murmur	Yes_____ No_____
Heart Attack	Yes_____ No_____
Irregular Heartbeat	Yes_____ No_____
Chest Pain	Yes_____ No_____
Heart Failure	Yes_____ No_____
Swelling of Hands	Yes_____ No_____
Swelling of Feet	Yes_____ No_____
Heart Valve Problems	Yes_____ No_____
High Blood Pressure	Yes_____ No_____
Varicose Veins	Yes_____ No_____
Cholesterol	Yes_____ No_____
Blood Clots	Yes_____ No_____
Stroke	Yes_____ No_____

Explain_____

_____

Any problems with your **Muscles or Bones**?

Neck injury	Yes_____ No_____
Back injury	Yes_____ No_____
Arthritis	Yes_____ No_____
Fractures	Yes_____ No_____
Bursitis	Yes_____ No_____
Tendonitis	Yes_____ No_____

Explain_____

_____

Any problems with your **Nervous System**?

Seizures	Yes_____ No_____
Epilepsy	Yes_____ No_____
Migraines	Yes_____ No_____
Numbness to arms	Yes_____ No_____
Numbness to legs	Yes_____ No_____
Extreme Nervousness/ anxiety	Yes_____ No_____
Depression	Yes_____ No_____
Ever had a head injury?	Yes_____ No_____

Explain_____

_____

Any problems with your **Digestive System**?

Weight Loss	Yes_____ No_____ Amount: _____
Weight Gain	Yes_____ No_____ Amount: _____
Difficulty Swallowing	Yes_____ No_____
Indigestion	Yes_____ No_____
Pain in Abdomen	Yes_____ No_____
Nausea/Vomiting	Yes_____ No_____
Ulcers	Yes_____ No_____
Diarrhea	Yes_____ No_____
Constipation	Yes_____ No_____
Blood in stool (black)	Yes_____ No_____
Hepatitis	Yes_____ No_____
Pancreatitis	Yes_____ No_____
Gallbladder problems	Yes_____ No_____
Collitis	Yes_____ No_____
Diverticulitis	Yes_____ No_____
Crohns	Yes_____ No_____

Explain_____

_____

List any **Skin Conditions**:_____

_____

Do you have or have you ever had **Cancer**? No___Yes___

If yes, what kind?_____

What type of treatment did you receive?_____

Any problems with your **Lungs or Breathing**?

Shortness of Breath at rest	Yes____ No____
Shortness of Breath on exertion	Yes_____ No_____
Asthma	Yes_____ No_____
Pneumonia	Yes_____ No_____
Bronchitis	Yes_____ No_____
Emphysema	Yes_____ No_____
Frequent Cough	Yes_____ No_____
Do you cough up anything?	Yes_____ No_____
Do you require oxygen therapy?	Yes_____ No_____
Do you smoke?	Yes_____ No_____

If yes, how much? _____

How long? _____

If no, did you ever smoke? Yes_____ No_____

How long?_____

When did you quit?_____

Any of the following?

Glaucoma	Yes_____ No_____
Cataracts	Yes_____ No_____
MRSA	Yes_____ No_____
Syphilis	Yes_____ No_____
Gonorrhea	Yes_____ No_____
Herpes	Yes_____ No_____
Hysterectomy	Yes_____ No_____
Are you pregnant?	Yes_____ No_____

# of Pregnancies____ # of Live Births_____

Last Menstrual Period_____

Any problems with your **Kidneys or Bladder**?

Frequent Infections	Yes_____ No_____
Kidney Stones/Disorder	Yes_____ No_____
Prostate Problems	Yes_____ No_____
Renal Failure	Yes_____ No_____

Explain_____

_____

Any problems with your **Blood**?

Anemia	Yes_____ No_____
Prolonged Bleeding	Yes_____ No_____
Easy Bruising	Yes_____ No_____
Sickle Cell Disease	Yes_____ No_____
Blood Transfusions	
From Blood Bank	Yes_____ No_____
Self Donated	Yes_____ No_____
Any Blood Diseases	Yes_____ No_____

Explain_____

_____

Any problems with your **Thyroid**? Yes_____ No_____

Are you **Diabetic**? Yes_____ No_____

How is this controlled?

Insulin____ Oral Medication ____ Diet____

Do you drink Alcohol? Yes_____ No_____

If yes, how much? _____

Do you do any street drugs (ex. Cocaine, Marijuana)?

Yes_____ No_____ Type_____

Any other health problems?_____

Do you have or have ever had any **Auto Immune Diseases**?

Lupus	Yes_____ No_____
Multiple Sclerosis	Yes_____ No_____
Rheumatoid Arthritis	Yes_____ No_____
Any not listed	Yes_____ No_____

PAIN ASSESSMENT

Patient's Name: _____ DOB:_____

Rate (0 no pain – 10 the most severe pain)_____

Location_____

Type:

Burning Dull
Pressure Heavy
Sharp Cramping
Other_____
_____

What makes your pain worse?_____
_____

How is your pain relieved?

Rest Heat
Cold Medications

Duration: Constant Intermittent

Do you have trouble controlling bowels or bladder?

Yes_____ No_____

Any other information we need to know? _____
_____
_____

If you have already had a procedure, how much of your pain is relieved? _____

0 relief ¼ ½ ¾ 100% relief

Shade in the total area of pain on the following diagram.

Right Left Left Right