

# SnyderChiropracticCare

For better health & wellness

## Patient Health Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

How often do you experience your symptoms? Indicate where you have pain or other symptoms.

- (1) Constantly (76-100% of the time)
- (2) Frequently (51-75% of the time)
- (3) Occasionally (26-50% of the time)
- (4) Intermittently (0-25% of the time)

What describes the nature of your symptoms?

- (1) Sharp
- (2) Dull ache
- (3) Numb
- (4) Shooting
- (5) Burning
- (6) Tingling

How are your symptoms changing?

- (1) Getting Better
- (2) Not Changing
- (3) Getting Worse

During the past 4 weeks:

None

Unbearable

Indicate the average intensity of your symptoms: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

How much has pain interfered with your normal work? (including both work outside the home and housework)

- (1) Not at all
- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)

- (1) None of the time
- (2) A little of the time
- (3) Some of the time
- (4) Most of the time
- (5) All of the time

In general, would you say your overall health right now is...

- (1) Excellent
- (2) Very Good
- (3) Good
- (4) Fair
- (5) Poor

Whom have you seen for your symptoms?

- (1) No one
- (2) Chiropractor
- (3) Medical Doctor
- (4) Physical Therapist
- (5) Other

What treatment did you receive and when? \_\_\_\_\_

What tests have you had for your symptoms and when were they done?

- (1) X-rays Date: \_\_\_\_\_ (3) CT Scan Date: \_\_\_\_\_
- (2) MRI Date: \_\_\_\_\_ (4) Other Date: \_\_\_\_\_

Have you had similar symptoms in the past? (1) Yes (2) No

If you have received treatment in the past for the same or similar symptoms, whom did you see?

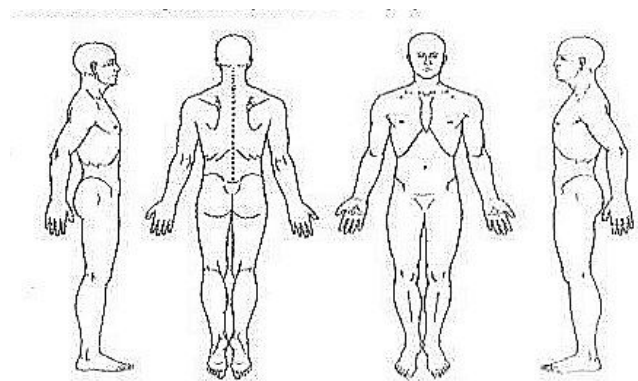
- (1) This office
- (2) Chiropractor
- (3) Medical Doctor
- (4) Physical Therapist
- (5) Other \_\_\_\_\_

What is your occupation? (1) Professional/Executive (2) White collar/secretarial (3) Tradesperson (4) Laborer  
(5) Homemaker (6) FT Student (7) Retired (8) Other

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Patient Health Questionnaire (continued)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

What is your height and weight? Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight \_\_\_\_\_ pounds

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

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:

\_\_\_\_\_

\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Doctor's Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_