PATIENT HEALTH QUESTIONNAIRE

Update Patients complete all questions.   New Injury Patients complete name, numbers 1 – 10 & Signature/Date

Patient Name ______________________________________ **Soc. Sec. #** ______________________**DOB** ____________
FIRST   MI   LAST

Address ____**City** ________________ **State** ________ **Zip** ____________

Home Phone (____) ________________ **Work # (____)** ________________ **Cell# (____)** ________________________

Marital Status: M S D W   # Children ___

Email Address: ____

Employer ________________________________ **Occupation** ____

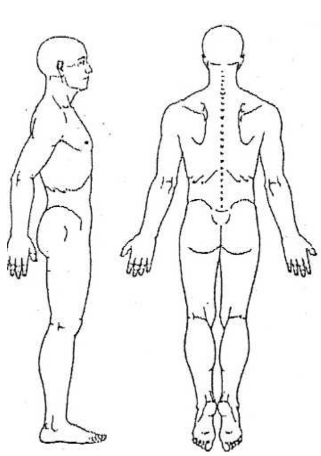
Insurance ____ **Spouse/Guardian** ____________________________

CHIEF COMPLAINT: PURPOSE OF THIS APPOINTMENT: ____

Date symptoms appeared or accident happened: ____

Is this due to: Auto____ Work____ Other____

PLEASE INDICATE ON BODY WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:



What describes the nature of your symptoms?

__Sharp   __Shooting   __Numb
__Dull Ache   __Burning   __Tingling

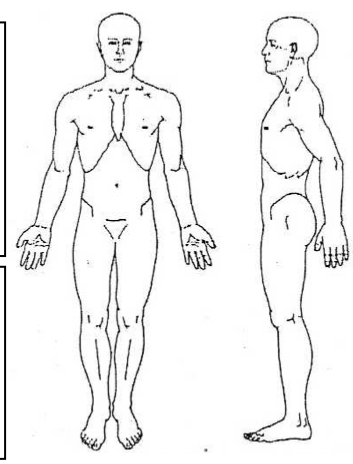
How are your symptoms changing?

__Getting Better   __Not Changing   __Getting Worse

Put an "X" on line below to indicate level of problem:

NO SYMPTOMS   **EXTREME SYMPTOMS**

0   1   2   3   4   5   6   7   8   9   10



In general would you say your overall health right now is…

__Excellent   __Very Good   __Good   __Fair   __Poor

Since your last visit to our office have you had any fractures? _____ **falls?** ______ **serious illness?** _____ **motor vehicle accident?** ____

Have you ever had the same or similar condition? Yes No If yes, when and describe: ______________________________
____

Have you seen another doctor for this condition? Yes No
____

Days lost from work: ______________________________

Medications you are currently taking: ____

Female: Is there a possibility that you might be pregnant? ____________________________________

Patient/Parent/Guardian Signature ____ **Date** ______________

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(Rev. 03/19/07) Office Use Only: GS _______   INS _______   GU_______   FLDR_______   CRDS_______   OVER ---