Name:_________________________________ Date:__________________________________

PATIENT HEALTH QUESTIONNAIRE

Height: _________________________________ Weight (lbs.): ___________________________

Please check the conditions you are experiencing and those you have experienced in the past.

Present	More than a year ago	Condition	Present	More than a year ago	Condition
_____	_____	Headache	_____	_____	Poor Circulation
_____	_____	Fainting	_____	_____	Difficulty with Urination
_____	_____	Dizziness	_____	_____	Prostate Trouble (Men)
_____	_____	Convulsions	_____	_____	Kidney Stones
_____	_____	Allergies	_____	_____	Bowel Trouble
_____	_____	Ringing in the Ears	_____	_____	Difficult Digestion
_____	_____	Blurred Vision	_____	_____	Heartburn
_____	_____	Chest Pain	_____	_____	Nausea
_____	_____	Difficulty Breathing	_____	_____	Neck Pain
_____	_____	High Blood Pressure	_____	_____	Back Pain
_____	_____	Swelling of the Ankles	_____	_____	Pain Radiating to Arms / Legs
_____	_____	Numbness or tingling in Arms or Legs			
_____	_____	Weakness of Hands or Arms			
_____	_____	Joint Pain at Shoulder, Elbow or Wrist			
_____	_____	Joint Pain of Ankle, Knee or Hip			
_____	_____	Arthritis of any Specific Joint Please specify: ______________________________			

Date of Last Menstrual Cycle (Women Only - Required for X-Rays) : mm____ dd ____ yyyy _______

Are you on Birth Control Pills (Women) ☐Yes ☐No

Any problems with your Menstrual Cycle (Women) ☐Yes ☐No

Do you Smoke? ☐Yes ☐No #per Day ________

Have you ever been told you have any disease? (Syndrome) Ex: Diabetes, Fibromyalgia etc.

____

Have You Had Any Form of Cancer?____

Any Family History of Cancer?____

Are You Physically Active?____

Does Your Job Require Physical Activity?____

Do others in your workplace have similar problems?_______________________________

Is there spinal or neurological troubles in your family?_____________________________

List Any Medications you are presently taking, or have taken in the past 3 months:

____

List all prior surgeries, if any:

____

List all prior accidents, falls, or broken bones, if any:

____

What is your purpose for coming to this office?

☐ Pain Relief Only ☐ Correction of Underlying Conditions ☐ To be Healthier