LOGAN UNIVERSITY
CHIROPRACTIC HEALTH CENTERS

Patient Health Questionnaire

First Name: _____ **Initial:** _____ **Last Name:** _____

Please describe your symptom(s):

_____

***When* did your symptom(s) start?**

_____

***How* did your symptom(s) start – can you identify a reason for your symptoms?**

_____

How often do you experience your symptom(s)?

□ Constantly (all day) □ Frequently (most of the day)
□ Occasionally (some of the day) □ Intermittently (off and on during the day)

Which term describes the nature of your symptom(s)?

□ Sharp □Numb □ Burning □ Dull ache □ Shooting □ Tingling □ Other

Are your symptom(s) changing? □ Getting better □ Not changing □ Getting worse

During the *past four weeks*:

What has been the <u>average</u> intensity of your symptom(s)?

Very mild ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Unbearable

How much have your symptom(s) interfered with your normal daily work routine? □ Not at all □ A little bit □ Moderate □ Quite a bit □ A lot

How much have your symptom(s) interfered with your social activities?

□ Not at all □ A little bit □ Moderate □ Quite a bit □ A lot

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

□ Excellent □ Very good □ Good □ Fair □ Poor

Who have you seen for your current symptom(s)?

□ No one □ Chiropractor □ Medical doctor □ Physical therapist □ Other:_____

If you received treatment for your symptom(s), please describe the type of treatment and when received:

_____

What tests have you had for your symptom(s) and *when*?
□ None □ X-Rays _____ □ MRI _____ □ CT Scan _____ □ Lab _____ □ Other _____

Have you had a similar problem in the past? □ Yes □No

If you have received treatment in the past for the same/similar symptoms, who did you see?
□ Logan chiropractor □ Non-Logan chiropractor □ Medical doctor
□ Physical therapist □ Other: _____

What is your occupation?_____
□ Professional/Executive □ White collar □ Tradesperson □ Laborer □ Homemaker
□ Full time student □ Retired □ Other

What is your current employment status? □ Full-time □ Part-time □ Unemployed □ Other

Past Medical History: In order to provide you with the best care possible, we need to know as much as possible about your past medical history. Please look over the lists below, and place an "**X**" next to any condition, symptom, or illness that you have NOW or have ever had in the PAST.

____Heart Disease
____Pacemaker
____Stroke
____Vascular Disease
____Hyper- or Hypotension
____Cancer
____HIV/AIDS
____Multiple Sclerosis
____Neurological Disease
____Fractures
____Spinal/Head Injury
____Osteoporosis
____STD
____Bleeding Disorder
____Diabetes
____Epilepsy
____Arthritis
____Rheumatoid Arthritis
____GI Disorders
____Back pain
____Herniated disk
____Numbness in arm or leg
____Pain in arm or leg
____Pinched nerve
____Tension/stiffness
____Weakness
____Headache

____Anorexia/Bulimia
____Depression
____Anxiety/Panic Attack
____Tuberculosis
____Emphysema
____Allergies
____Asthma
____Kidney Disease
____Liver Disease
____Prostate Disease
____Ulcers
____Hernia
____Thyroid Disease
____Gout
____Typhoid Fever
____Scarlet Fever
____Rheumatic Fever
____Measles/Mumps
____Mononucleosis

MEN ONLY:
____Testicular lump
____Penis discharge

____Trouble sleeping
____Nervousness
____Dizziness/Vertigo
____Unexplained weight loss
____Fatigue
____Night sweats
____Nausea
____Unexplained Fever
____Excessive hunger/thirst
____Bowel problems
____Urination problems
____Sexual dysfunction
____Chest pain
____Heart palpitations
____Vision problems
____Cold hands/feet
____Ringing in ear(s)
____Persistent cough
____Bruise easily

WOMEN ONLY:
____Breast lump
____Menstrual pain
____Abnormal bleeding
____Vaginal Discharge
____Nipple Discharge