PATIENT HEALTH QUESTIONNAIRE ATTLEBORO CHIROPRACTIC HEALTH CENTER, INC.

Name: _____

Describe your symptoms: _____

_____

_____

When did your symptoms start? _____

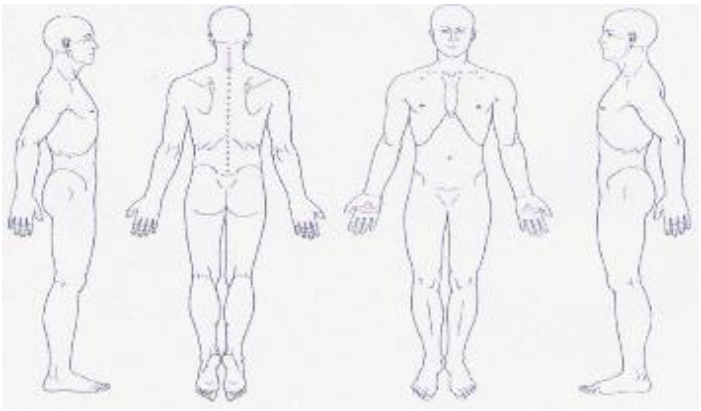
How did your symptoms begin? _____

_____

How often do you experience these symptoms?
- ❑ Constant (76-100% of the day)
- ❑ Frequent (51-75% of the day)
- ❑ Intermittent (26-50% of the day)
- ❑ Occasional (0-25% of the day)

Describe the nature of your symptoms?
- ❑ Sharp ❑ Dull ache ❑ Numb
- ❑ Shooting ❑ Burning ❑ Tingling
- ❑ Other _____

How are your symptoms changing?
- ❑ Getting Better
- ❑ Not Changing
- ❑ Getting Worse



Indicate where you have pain or other symptoms

Rate your pain (at best and worst) None ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 Unbearable

What activities make your symptoms worse?_____

What activities make you symptoms better? _____

Do you experience fever or chills? ❑ Yes ❑ No

Does the pain affect your sleep? ❑ Yes ❑ No

Are there any changes in bowel or bladder function? ❑ Yes ❑ No

Who have you seen for your present complaint? ❑ No One ❑ Medical Doctor ❑ Chiropractor ❑ Physical Therapist ❑ Other: _____

What tests were performed? ❑ X-ray ❑ MRI ❑ CT Scan ❑ Other

Have you had similar symptoms in the past? ❑ Yes ❑ No

What treatment did you receive? _____

Have you lost time from work or school? ❑ Yes ❑ No

If Yes, How much time? _____

Have you returned to work/school? ❑ Yes ❑ No

❑ Full Duty ❑ Light Duty

What do you hope to get from your treatment? (select all that apply)
- ❑ Reduce symptoms
- ❑ Explanation of condition/treatment
- ❑ How to prevent future episodes
- ❑ Resume/Increase activity
- ❑ _____

Patient Signature: _____ Date: _____

Exam: IN RE1 RE2 RE3 DC / RA RA1 RA2 RA3