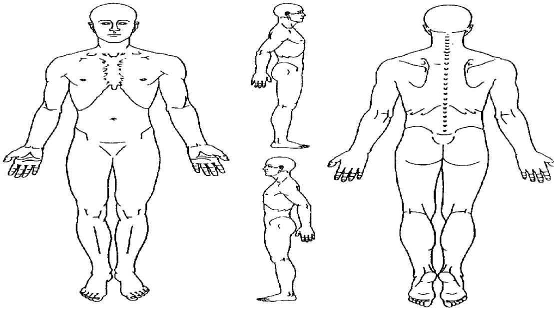
Life Chiropractic & Wellness Center

Patient Health Questionnaire

Patient Name: ____________________________________ Date: _____________________

ST – Stiffness **TG** – Tightness **D** – Dull **C** - Continuous **A**- Ache

SH – Shooting **N**- Numbness **SP**- Sharp **B**- Burning **T**- Tingling **TH**- Throbbing



1st Complaint ______________________________

When did it start? __________________________

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

What makes your symptoms worse?

____

What makes your symptoms better?

____

When is it the worse? ☐ Morning

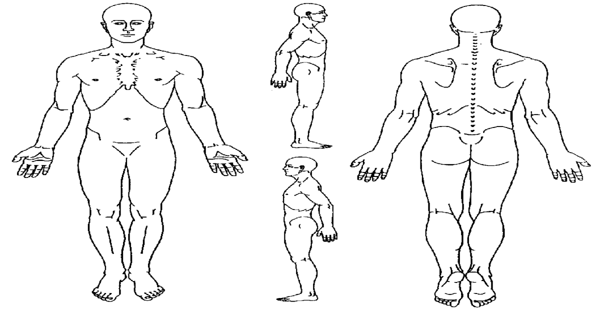
☐ Afternoon ☐ Evening ☐ Just before bed

Have you received treatment for this symptom?

If so, what? ________________________________

Have you had similar symptoms in the past?

If so, when? ________________________________



2nd Complaint ______________________________

When did it start? ___________________________

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?

☐ Getting Better ☐Not Changing ☐ Getting Worse

What makes your symptoms worse?

____

What makes your symptoms better?

____

When is it the worse? ☐ Morning

☐ Afternoon ☐ Evening ☐ Just before bed

Have you received treatment for this symptom?

If so, what? ________________________________

Have you had similar symptoms in the past?

If so, when? ________________________________

Additional Health Complaints/Concerns: ____

____

What do you hope to get from your visit / treatment ? (select all that apply)

☐ Reduce symptoms ☐ Explanation of condition / treatment ☐ Resume / increase activity

☐ Learn how to take care of this on my own ☐ How to prevent this from occurring again

MUSCULO-SKELETAL

Past Present

- ___ ___ Neck pain
- ___ ___ Ear pain
- ___ ___ Jaw pain
- ___ ___ Throat pain
- ___ ___ Shoulder pain L. R.
- ___ ___ Arm pain L. R.
- ___ ___ Elbow pain L. R.
- ___ ___ Wrist pain L. R.
- ___ ___ Hand pain L. R.
- ___ ___ Pain between the shoulders
- ___ ___ Mid / upper back pain
- ___ ___ Chest pain L. R.
- ___ ___ Stomach pain L. R.
- ___ ___ Low back pain
- ___ ___ Buttock pain
- ___ ___ Hip Pain L. R.
- ___ ___ Leg pain L. R.
- ___ ___ Knee pain L. R.
- ___ ___ Ankle pain L. R.
- ___ ___ Foot pain L. R.
- ___ ___ Toe pain L. R.
- ___ ___ Muscle spasms
- ___ ___ **Sciatica**
- ___ ___ Spinal Curvature

FEMALES ONLY

- ___ ___ Cramps or Backache
- ___ ___ Menopausal Symptoms
- ___ ___ Birth Control Pills
- ___ ___ Abnormal Menstruation

Are You Pregnant? ☐ Yes ☐ No

GASTRO-INTESTINAL

Past Present

- ___ ___ Bloating
- ___ ___ Constipation
- ___ ___ Diarrhea
- ___ ___ Heartburn
- ___ ___ Hemorrhoids
- ___ ___ Nausea
- ___ ___ Stomach pain
- ___ ___ Ulcers
- ___ ___ Vomiting
- ___ ___ Gall Bladder
- ___ ___ Irritable Bowel Syndrome

GENITO-URINARY

Past Present

- ___ ___ Bladder Infection
- ___ ___ Blood in Urine
- ___ ___ Kidney Disorder
- ___ ___ Lack of Bladder control
- ___ ___ Painful Urination
- ___ ___ Prostate Problems

CARDIO-VASCULAR

Past Present

- ___ ___ Chest Pain
- ___ ___ Heart Attack
- ___ ___ High Blood Pressure
- ___ ___ Low Blood Pressure
- ___ ___ Irregular Heart Beat
- ___ ___ Poor Circulation
- ___ ___ Stroke
- ___ ___ Varicose Veins

GENERAL

Past Present

- ___ ___ Arthritis
- ___ ___ Alcohol Dependency
- ___ ___ Asthma
- ___ ___ Cancer
- ___ ___ Depression
- ___ ___ Diabetes
- ___ ___ Dizziness
- ___ ___ Drug Dependency
- ___ ___ Epilepsy
- ___ ___ Fainting
- ___ ___ Fatigue
- ___ ___ Forgetfulness
- ___ ___ Frequent Colds/Flu
- ___ ___ Headache
- ___ ___ Hepatitis
- ___ ___ HIV / Aids
- ___ ___ Irritable
- ___ ___ Loss of Balance
- ___ ___ Loss of Sleep
- ___ ___ Loss of Appetite
- ___ ___ Lupus
- ___ ___ Migraines
- ___ ___ Nervousness
- ___ ___ Rheumatoid Arthritis
- ___ ___ Stress
- ___ ___ Stutter
- ___ ___ Ringing in ears
- ___ ___ Sinus allergies
- ___ ___ Shortness of Breath
- ___ ___ C-Pap

Other: ___________________________

INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:

___Rheumatoid Arthritis ___Heart Problems ___Diabetes ___Cancer ___Lupus ___High/Low Blood Pressure

List all prescription and over-the-counter medications, and nutritional/herbal supplements your are taking:

Name	Dosage	Name	Dosage
____________________	__________	____________________	__________
____________________	__________	____________________	__________
____________________	__________	____________________	__________
____________________	__________	____________________	__________

Pharmacy: ____________________________________ ***Location:*** ____________________________________

List all **Drug Allergies***:* ________________________ ________________________ ________________________

List all **Surgical Procedures***:* ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

PATIENT SIGNATURE: ____ ***DATE:*** ____________________________