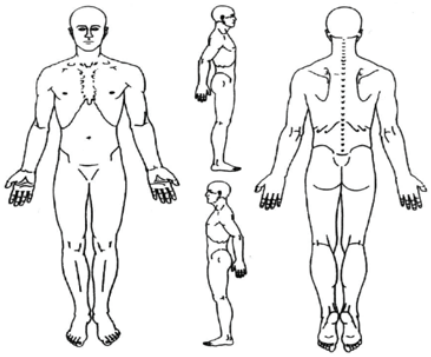
Patient Health Questionnaire

Name: _____ Date: _____

Please describe your chief concern: _____

When did it begin? _____ **How did it begin?** _____

(Mark the area of pain/symptoms)



(Front) (Back)

(Dr. Notes)

Description		**Frequency**	What Makes Concern **Better?**		What Makes It **Worse?**	
☐ Sharp	☐ Numb	☐ Constant (76–100%)	☐ Nothing	☐ Sitting	☐ Nothing	☐ Sitting
☐ Dull	☐ Shooting	☐ Frequent (51–75%)	☐ Lying Down	☐ Exercise	☐ Lying Down	☐ Exercise
☐ Ache	☐ Gripping	☐ Occasional (26–50%)	☐ Walking	☐ Inactivity	☐ Walking	☐ Inactivity
☐ Weak	☐ Burning	☐ Intermittent (25% or less)	☐ Standing	☐ Ice/Heat	☐ Standing	☐ Ice/Heat
☐ Throbbing	☐ Tingling					

INDICATE the intensity of your pain at it's **LOWEST** & **HIGHEST** level.

No Pain — Unbearable Pain

1 2 3 4 5 6 7 8 9 10

Current weight _____ lbs

height _____

Your Symptoms are:

☐ Decreasing
☐ Not Changing
☐ Increasing

Worse at:

☐ Morning
☐ Night
☐ Daytime
☐ Same all day

Please rate your stress level

☐ No Stress
☐ Mild Stress
☐ Moderate Stress
☐ Significant Stress

Has this concern impacted your level of stress?

☐ Yes ☐ No

Indicate any tests or treatments that you have had for this condition (include location and year):

☐ Injection _____ ☐ Surgery _____
☐ X-rays _____ ☐ MRI _____
☐ CT/CAT Scans _____ ☐ EMG _____
☐ Physical Therapy _____ ☐ Other _____

How is your concern affecting daily activities?

☐ No effect
☐ Able to perform light duty only
☐ Need assistance with common tasks
☐ Inability to function without assistance
☐ Totally impaired/disabled

Current Work Status

☐ Full Time ☐ Unemployed
☐ Part Time ☐ Retired
☐ Off Work ☐ Full-time student
☐ Restrictions ☐ Other

Work Description: _____

☐ I have received the HIPPA Privacy Practice Act from Valley Chiropractic Associates

Valley Chiropractic Associates Signature: _____ Date: _____