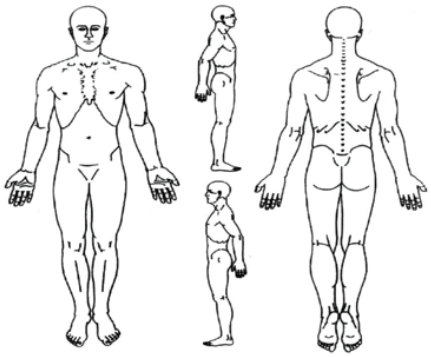
Patient Health Questionnaire

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: _____

REPORT ACCIDENT TO/ACCIDENT WITNESS

What date did you report this injury?_____

Whom did you report this to? _____ What is their position? _____

Was there a witness to your injury? ☐ Yes ☐ No

If yes, what is the witness' name? _____ What is their position? _____

Other witness name? _____ Position? _____

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints **just before this accident?** ☐ Yes ☐ No

If yes, please describe any physical complaints **just before this accident?** _____

_____

Have you EVER had any PRIOR injuries, accidents, diseases, or treatments to the area of your body now affected? ☐ Yes ☐ No

If yes, state what part of your body was previously injured _____

Describe the injury _____

Were you treated? ☐ Yes ☐ No If yes, who treated you? _____

What date did the treatment begin? _____ When did treatment end? _____

When was the last time (date) you felt pain or problems from that injury? _____

WORK STATUS HISTORY

Have you lost any time from work as a result of this new injury? ☐ Yes ☐ No

If yes, give dates and time of loss: _____

If you are currently on **disability (time loss),** do you want to go back to doing your **regular** work duties? ☐ Yes ☐ No

If no, state why _____

Have you gone back to work? ☐ Yes ☐ No If yes, when? _____ Status ☐ Modified ☐ Regular

Please list any restrictions you have been placed on _____

If you have gone back to work please list the activities as:

Those that are painful _____

Those that are difficult _____

ACTIVITIES OF DAILY LIVING

Do you find any activities that you perform at *home* **painful** or **difficult?** ☐ Yes ☐ No

If yes, those home activities that

You are unable to do are: _____

Are difficult to do are: _____

Do you have an attorney on this case? ☐ Yes ☐ No If yes, whom? _____

****I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.**

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE, AND AGREE TO ABIDE BY SAME.

Patient Signature _____ Date: _____

Guardian Signature _____ (If patient is under 18)