Patient Health Questionnaire

ChiroCare of Minnesota, Inc.

ChiroCare Usa Only *rev* 4/19/99

Patient Name _____ *Date* _____

1. *When did your symptoms start:* _____
   Describe your symptoms and how they began: _____

_____

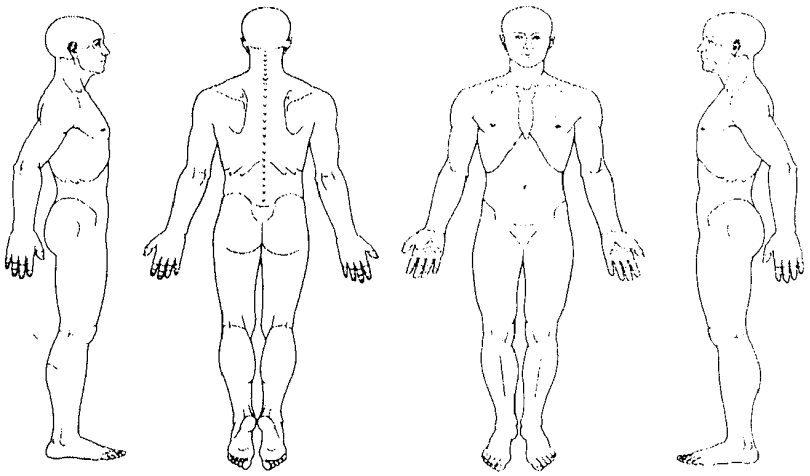
_____

2. *How often do you experience your symptoms?*
   (1) Constantly (76-100% of the day)
   (2) Frequently (51-75% of the day)
   (3) Occasionally (26-50% of the day)
   (4) Intermittently (0-25% of the day)

3. *What describes the nature of your symptoms?*
   (1) Sharp (4) Shooting
   (2) Dull ache (5) Burning
   (3) Numb (6) Tingling

   How are your symptoms changing?
   (1) Getting Better
   (2) Not Changing
   (3) Getting Worse

Indicate where you have pain or other symptoms



5. *How bad are your symptoms at their:*

	None										Unbearable
a. *Worst:*	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
b. *Best*	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

6. *How do your symptoms affect your ability* to *perform daily activities?*

(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
No complaints	*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*			*Severe, no activity possible*

7. *What activities make your symptoms worse:* _____

8. *What activities make your symptoms better:* _____

Who have you seen for your symptoms?
(1) No One
(2) Other Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

a. *When and what treatment?* _____

b. What tests have you had for your symptoms and when were they performed?
(1) Xrays *date:* _____
(2) MRI *date:* _____
(3) CT Scan *date:* _____
(4) Other *date:* _____

10. *Have you had similar symptoms in the past?* (1) Yes (2) No

a. *If you have received treatment in the past for the same or similar symptoms, who did you see?*
(1) This Office
(2) Other Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

11. *What is your occupation?*
(1) Professional/Executive
(2) White Collar/Secretarial
(3) Tradesperson
(4) Laborer
(5) Homemaker
(6) FT Student
(7) Retired
(8) Other

_____

a. *If you are not retired,* a *homemaker, or* a *student, what is your current work status?*
(1) Full-time
(2) Part-time
(3) Self-employed
(4) Unemployed
(5) Off work
(6) Other

12. *What do you hope to get from your visit/treatment (select all that apply)*
(1) Reduce Symptoms
(2) Resume/increase activity
(3) Explanation of condition/treatment
(4) Learn how to take care of this on my own
(5) How to prevent this from occurring again (6)

Patient Signature _____ *Date* _____