Patient Health Questionnaire - Page 2

ChIroCare of Minnesota. Inc. *ChiroCare Use Only rev 1/20/99*

Patient Name _____ *Date* _____

What type of *regular exercise do you perform?* (1) None (2) Light (3) Moderate (4)Strenuous

What is your height and weight? Height:_____ Weight:_____

For each of *the conditions listed below, place* a *check in the Past column if you have had the condition in the past.*
If you presently have a *condition listed below, place* a *check in the Present column.*

Past	*Present*			*Past*	*Present*		
O	O Headaches	O	O High Blood Pressure	O	O Diabetes		
O	O Neck Pain	O	O Heart Attack	O	O Excessive Thirst		
O	O Upper Back Pain	O	O Chest Pains	O	O Frequent Urination		
O	O Mid Back Pain	O	O Stroke				
O	O Low Back Pain	O	O Angina	O	O Smoking/Use Tobacco Products		
				O	O Drug/Alcohol Dependence		
O	O Shoulder Pain	O	O Kidney Stones				
O	O Elbow/Upper Arm Pain	O	O Kidney Disorders	O	O Allergies		
O	O Wrist Pain	O	O Bladder Infection	O	O Depression		
O	O Hand Pain	O	O Painful Urination	O	O Systemic Lupus		
		O	O Loss of Bladder Control	O	O Epilepsy		
O	O Hip/Upper Leg Pain,	O	O Prostate Problems	O	O Dermatitis/Eczema/Rash		
O	O Knee/Lower Leg Pain			O	O HIV/AIDS		
O	O Ankle/Foot Pain	O	O Abnormal Weight Gain/Loss				
				Females Only			
				O	O Birth Control Pills		
O	O Joint Swelling/Stiffness	O	O Ulcer	O	O Hormonal Replacement		
O	O Arthritis	O	O Hepatitis	O	O Pregnancy		
O	O Rheumatoid Arthritis	O	O Liver/Gall Bladder Disorder	O	O		
O	O General Fatigue	O	O Cancer	*Other Health Problems/Issues*			
O	O Muscular Incoordination	O	O Tumor	O	O		
O	O Visual Disturbances	O	O Asthma	O	O		
O	O Dizziness	O	O Chronic Sinusitis	O	O		

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus

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

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ *Date* _____

Doctors Additional Comments:

Doctors Signature _____ *Date* _____