SCHUBBE RESCH CHIROPRACTIC & PT CENTER – APPLETON 920-738-0200 / NEENAH 920-720-0660

## PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: ______________________ DOB: ________ Age: ____ SS # ____________ Cell: ____________ Phone: ____________

Primary Care Dr. ______________________________ Who referred you here? ______________________

Employer: ____________________ Occupation: ______________ Email address______________________

Race: __ American Indian / Alaskan Native __ Asian __ Black / African American __ Native Hawaiian /Pacific Islander ___ White ___ Other _______

Preferred Language: ___ English ___ Other ________

Ethnicity: ___ Hispanic ___ Non Hispanic

1. List your complaint(s) and rate the level of discomfort on a scale of 1-10 (1 = lowest - 10 = highest)

   Primary Complaint ______________________________(left/right) Discomfort Level 1 2 3 4 5 6 7 8 9 10

   Secondary Complaint ______________________________(left/right)Discomfort Level 1 2 3 4 5 6 7 8 9 10

   Tertiary Complaint ______________________________(left/right)Discomfort Level 1 2 3 4 5 6 7 8 9 10

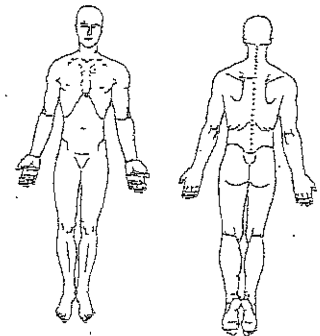
2. How would you describe your symptoms? ☐ Sharp ☐ Dull ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

3. When did your symptoms start? ______________ Cause if known: ☐ Work related ☐ Auto Accident ☐ Other

   If other, explain: ______________________________________________

4. How often do you experience your symptoms? Indicate on drawing below where you have pain or symptoms >>

   ☐ **Constantly** = 76-100% of the day
   ☐ **Frequently** = 51-75% of the day
   ☐ **Occasionally** = 26-50% of the day
   ☐ **Intermittently** = 0-25% of the day



5. How much has pain interfered with your normal work and social activity?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. Who have you seen for your symptoms? ☐ No one ☐ Other Chiropractor ☐ MD ☐ Phys. Therapist ☐ Other

   What treatment did you receive and when? ______________________________________

   What tests have you had for your symptoms and when were they performed?

   ☐ Xrays *date* ________ ☐ MRI *date* ________ ☐ CT Scan *date* ________ ☐ Other ____________ *date* ________

7. Have you had similar symptoms in the past? ☐ Yes ☐ No If yes, treated by whom ____________________

Please list prescription, over the counter medications or supplements you routinely take.

| Name of Medication | What is it for? | Dose and Frequency | When did you start? |
|---|---|---|---|
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8. Have you been hospitalized or had surgery? ☐ Yes ☐ No If yes, indicate below

______________________________________________________________________

9. Do you have allergies to medications? ___ Yes ___ No If yes, please list and describe below

| Medication | Mild | Mod | Severe | Describe Reaction |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

10. What was your most recent blood pressure reading (ex: 120/70)? _____ / _____

11. Height: ____ ft ____in

12. Weight : ________

13. Smoking Status: ____ Daily Smoker ____ Somedays Smoker ____ Former Smoker ____ Never Smoked

14. Do any of the following diseases run in your family (ex: Grandparents, parents, siblings, children)?

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke/anuersym ☐ Depression

15. Females, is there any chance you could be pregnant now? ☐ Yes ☐ No

**Past Medical History/Review of Symptoms** *circle all that apply*

High or low Blood pressure
Major Trauma falls/accidents
Anxiety Disorder
Gout
Aortic Aneurysm
HIV AIDS
Stroke TIA
Weakness in thighs/legs/feet
Numbness in Legs/Feet
Numbness in arms/hands
Difficulty Talking or Swallowing
Problems with Sexual Function

Abnormal Heart Valve
Emphysema
Depression
Arthritis
Migraine Headaches
Kidney Problems
Brain Aneurysm
Swelling in Feet & Ankles
Liver Problems
Easy Bleeding
Unexpected Weight Loss

Irregular Heart Beat
Tuberculosis
Cancer
Addiction to alcohol
Addiction to drugs
Osteoporosis
Ulcers (stomach)
Seizures
Broken Bones
Problems with Urination
Frequent Headache

Diabetes
Blood Clots
Heart Attack
Mental Illness
Thyroid Disease
Poor Circulation
Severe Head Injury
Broken Bones
Chills/Fevers
Bowel Problems

Difficulty Sleeping Y N

How long does it take to fall asleep? _______ How often do you wake? ______

Do you have long breathing pauses while sleeping? Y N

Signature______________________________________Date____________________