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 [ ] [ ] [ ] (Feet, Inches) Weight [ ] [ ] [ ] lbs.

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	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/Upper Leg Pain
O	O	Knee/Lower Leg Pain
O	O	Ankle/Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/Stiffness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness

Past	Present	
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Ulcer
O	O	Hepatitis
O	O	Liver/Gall Bladder Disorder
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitis

Past	Present	
O	O	Diabetes
O	O	Excessive Thirst
O	O	Frequent Urination
O	O	Smoking/Use Tobacco Product
O	O	Drug/Alcohol Dependence
O	O	Allergies
O	O	Depression
O	O	Systemic Lupus
O	O	Epilepsy
O	O	Dermatitis/Eczema/Rash
O	O	HIV/AIDS

Females Only

Past	Present	
O	O	Birth Control Pills
O	O	Hormonal Replacement
O	O	Pregnancy
O	O	

Other Health Problems/Issues

Past	Present	
O	O	
O	O	
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 O ____________

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** ____________

Doctor's Additional Comments

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Doctors Signature ____________________ **Date** ____________