

# 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 

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      Weight 

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 lbs.  
Feet      Inches

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.

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

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

- Rheumatoid Arthritis     Heart Problems     Diabetes     Cancer     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 \_\_\_\_\_

**Doctor's Additional Comments**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_