NAME_____ ADMIT DATE _____
MONTH DAY Y

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, pleas describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and pres symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

PATIENT HEALTH QUESTIONNAIRE

1. Present Complaint:_____

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Sorene ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant, (76–100%) ☐ Frequent (51–75%) ☐ Occasional (26–50%) ☐ Intermittent (25% or less).

4. How bad is your pain or ache? Please circle a number: 0 (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PA

5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. When did your problem begin: SPECIFIC DATE IF POSSIBLE? _____

7. Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time

8. Describe how your problem began: _____

9. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal injections ☐ Therapy from a PT ☐ A back support ☐ Other _____ If none check here ☐

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No. If yes by: ☐ Chiropractor ☐ MD ☐ Therapis ☐ Other _____ (SPECIFY DATES & TYPE OF TREATMENT WITH RESULTS) _____

11. What makes your problem better? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

12. What makes your problem worse? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

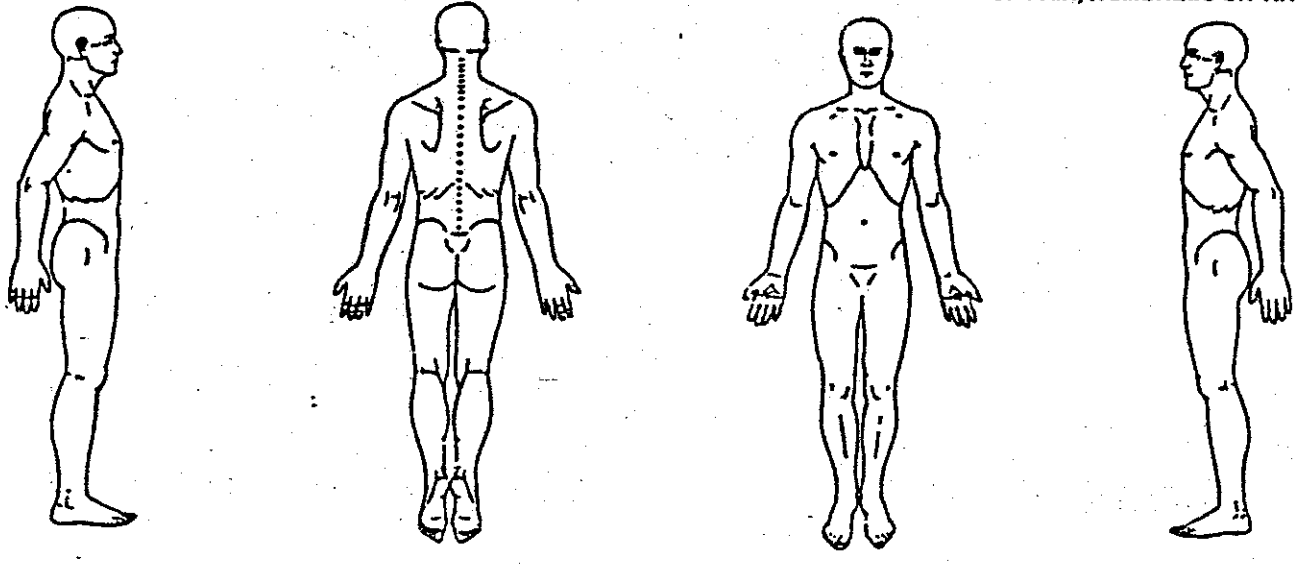
13. How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

14. Physical activity at work: ☐ Sedentary More Than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise Program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?
- ☐ No effect
- ☐ Some physical restrictions (able to perform light duty work and houshold tasks).
- ☐ Need limited assistance with common everyday tasks.
- ☐ Need assistance often.
- ☐ Have a significant inability to function without assistance.
- ☐ Am totally disabled (impaired). Cannot care for self.

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient's Signature:_____ Date:_____