ALL STAR HEALTH
SPINE & SPORTS CARE

PATIENT HEALTH QUESTIONNAIRE

NAME _____ **DATE**____/____/____

In the space below, please describe your major complaint.
If you have an additional complaint, please describe on page 2

1. Please Describe your Complaint: _____

_____

_____

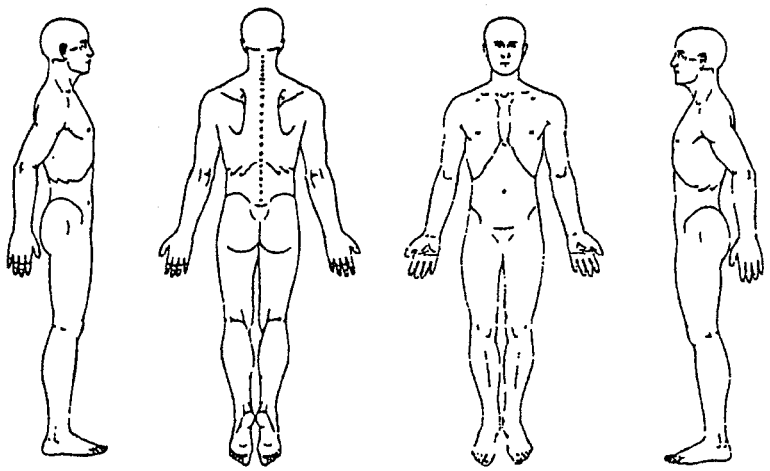
a. Description

- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency

- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (1-25%)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



c. Indicate intensity of your pain at its lowest and highest level No Pain [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Unbearable Pain

d. Your symptoms are ☐ decreasing ☐ not changing ☐ increasing

e. Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day

2. Date Problem Began: _____ Describe how your problem began: _____

_____

_____

3. Have you ever been treated *for this episode?* ☐ Yes ☐ No

If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____

Are you currently being seen? ☐ Yes ☐ No

When and what treatment?____/____/_____

_____

4. ***In the past*** have you ever been treated for the same or a similar problem? ☐ Yes ☐ No

If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____

When and what treatment did you receive? _____

_____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

7. How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

8. General Physical Activity: ☐ No regular Exercise program ☐ Light Exercise program ☐ Moderate Exercise program ☐ Strenuous Exercise program

9. Are your complaints affecting your ability to be active?

- ☐ No effect
- ☐ Need limited assistance with common everyday tasks.
- ☐ Have a significant inability to function without assistance.
- ☐ Some physical restrictions (able to perform light duty work and household tasks).
- ☐ Need assistance often.
- ☐ Am totally disabled (impaired). Cannot care for self.

10. Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion

11. Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No

12. What is your current work status?

- [1] Full time, no restrictions.
- [2] Full time, with restrictions.
- [3] Part time, with no restrictions.
- [4] Part time, with restrictions.
- [5] Off work due to restrictions.
- [6] Full time homemaker.
- [7] Unemployed.
- [8] Retired.
- [9] Full time student.
- [10] Other: _____

PLEASE CONTINUE ON PAGE 2.

Patient Signature: _____ **Date:** ____/____/____

MEDICAL HISTORY - REVIEW OF SYMPTOMS
CHECK SYMPTOMS/CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST

CONSTITUTIONAL
O LOSS OF APPETITE O FEVER O FATIGUE O WEIGHT
O NIGHT SWEATS O NAUSEA O VOMITING O CHILLS

CARDIOVASCULAR
O HYPERTENSION O CHEST PAIN O MURMUR
O HEART ATTACK O PACEMAKER O STROKE
O HIGH CHOLESTEROL O CLAUDICATION
O RAPID HEART BEAT

RESPIRATORY
O ASTHMA O DIFFICULTY BREATHING
O SLEEP APNEA O EMPHYSEMA O WHEEZING
O COUGH O SHORTNESS OF BREATH

GENITOURINARY
O KIDNEY STONES O BLADDER INFECTION
O PAINFUL URINATION O LOSS OF BLADDER CONTROL
O FREQUENT URINATION O KIDNEY DISORDERS
O URINARY TRACT INFECTION

SKIN
O RASH O ECZEMA O ACNE O PSORIASIS
O BREAST PAIN

PSYCHIATRIC
O ANXIETY O PANIC ATTACK O DEPRESSION O ADDICTION

ALLERGIC/IMMUNOLOGIC
O ALLERGIES O ITCHY EYES O SNEEZING
O RUNNY NOSE

EYES
O VISUAL DISTURBANCES O CONTACTS O GLASSES
O BLURRED VISION O CATARACTS O GLAUCOMA

EARS/NOSE/MOUTH/THROAT
O TINNITUS O RECURRING EAR INFECTIONS
O CHRONIC SINUSITIS O LOSS OF HEARING O JAW PAIN

GASTRONINTESTINAL
O ULCER O HEARTBURN O ABDOMINAL PAIN
O CONSTIPATION O LIVER PROBLEMS O DIARRHEA
O GALL BLADDER O DIFFICULTY SWALLOWING
O ACID REFLUX O HIATAL HERNIA

MUSCULOSKELETAL
O ARTHRITIS O RHEUMATOID ARTHRITIS O MUSCLE PAIN
O NECK PAIN O BACK PAIN O SHOULDER PAIN
O JOINT PAIN O FIBROMYALGIA O KNEE PAIN
O WRIST PAIN O FOOT PAIN O ARM PAIN
O GOUT O STIFFNESS O WEAKNESS
O BURSITIS O TENDONITIS O CARPAL TUNNEL

NEUROLOGICAL
O EPILEPSY O DIZZINESS O SEIZURES O SYNCOPE
O CONFUSION O VERTIGO O HEADACHE O TREMOR
O LOSS OF BALANCE O NUMBNESS O SLURRED SPEECH
O DIFFICULTY/CHANGE IN HANDWRITING

ENDOCRINE
O EXCESSIVE THIRST O FREQUENT URINATION
O ABNORMAL WEIGHT GAIN O ABNORMAL WEIGHT LOSS
O THYROID PROBLEMS O DIABETES

HEMATOLOGICAL/LYMPHATIC
O BLOOD DISORDER O CANCER O HIV/AIDS O TUMOR

FEMALE ONLY
O CURRENTLY PREGNANT O HORMONE REPLACEMENT
O ENDOMETRIOSIS O IRREGULAR MENSTRUAL FLOW
O PMS O PROFUSE MENSTRUAL FLOW
O INFERTILITY O TUBAL LIGATION
O MISCARRIAGE O MENOPAUSE

MALE ONLY
O ERECTILE DYSFUNCTION O PROSTATE PROBLEMS
O INFERTILITY O VASECTOMY

ALLERGIES
O NONE O MEDICATION O SEASONAL O FOOD O ANIMALS

FAMILY HISTORY
O CANCER O UNKNOWN
O RHEUMATOID ARTHRITIS O EPILEPSY
O DIABETES O CHRONIC BACK PROBLEMS
O HEART PROBLEMS O CHRONIC HEADACHES
O LUNG PROBLEMS O LUPUS
O STROKE O HIGH BLOOD PRESSURE
O _____

MEDICATIONS O NONE
1.
2.
3.
4.
5.

HOSPITALIZATIONS/FRACTURES O NONE
1.
2.
3.
4.

SURGERIES O NONE
O TONSIL/ADENOIDS O HEART O NECK
O APPENDIX O C-SECTION O LOW BACK
O GALL BLADDER O HYSTERECTOMY O _____

SOCIAL HABITS
O SMOKE 0 1/2 1 2 >2 PACKS/DAY
O DRINK ALCOHOL 0 1-3 4-7 >7 DRINKS/WEEK
O CAFFEINE 0 1-3 4-6 >6 CUPS/DAY
O CHILDREN 0 1 2 3 4 5 6 OTHER
O DRUG DEPENDENCE

EDUCATION (HIGHEST LEVEL COMPLETED)
O NONE O ELEMENTARY O JR. HIGH O HIGH SCHOOL O COLLEGE

DIET (MARK FREQUENTLY CONSUMED FOODS)
O BREAD O PASTA O CEREAL O FRUITS
O POP O COFFEE O WATER O VEGETABLES

VITAMINS/SUPPLEMENTS O NONE
O MULTI-VITAMIN O CO Q 10
O CALCIUM/MAGNESIUM O PROTEOLYTIC ENZYMES
O ESSENTIAL FATTY ACIDS O OTHER_____

SLEEP (AVERAGE HOURS PER DAY) 4 5 6 7 8 9 10 11 12 13

(POSITION) O SIDE O BACK O STOMACH

DATE:_____HEIGHT:_____WEIGHT:_____

ADDITIONAL INFORMATION - PATIENT:

PATIENT SIGNATURE_____

ADDITIONAL INFORMATION - PHYSICIAN:

PHYSICIAN SIGNATURE_____