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

***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** _____