

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name _____

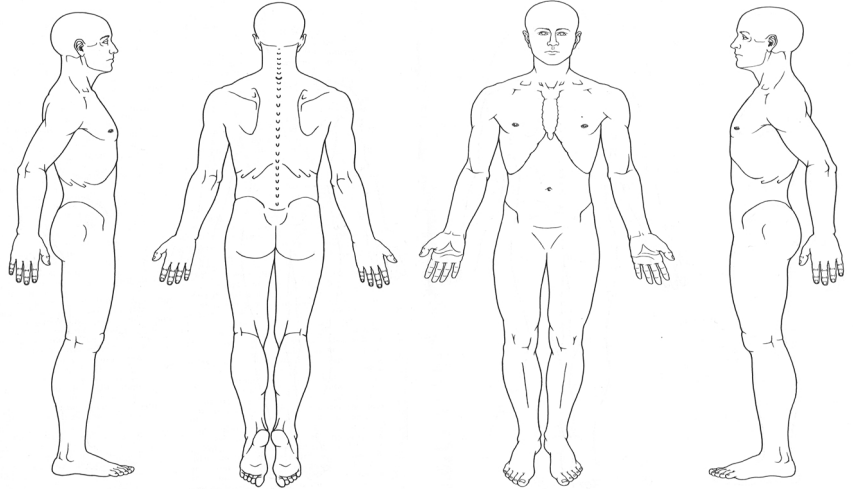
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ Severe, no activity possible

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

10. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature _____

Date _____

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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 Products
Shoulder Pain Kidney Stones Drug/Alcohol Dependence
Elbow/Upper Arm Pain Kidney Disorders Allergies
Wrist Pain Bladder Infection Depression
Hand Pain Painful Urination Systemic Lupus
Hip/Upper Leg Pain Loss of Bladder Control Epilepsy
Knee/Lower Leg Pain Prostate Problems Dermatitis/Eczema/Rash
Ankle/Foot Pain Abnormal Weight Gain/Loss HIV/AIDS
Jaw Pain Loss of Appetite
Joint Swelling/Stiffness Abdominal Pain
Arthritis Ulcer
Rheumatoid Arthritis Hepatitis
General Fatigue Cancer
Muscular Incoordination Tumor
Visual Disturbances Asthma
Dizziness Chronic Sinusitis

Females Only

- Birth Control Pills
Hormonal Replacement
Pregnancy

Other Health Problems/Issues

- [] []
[] []
[] []

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 _____

THE CENTER OF CHIROPRACTIC
402 South 6th Street La Crosse, WI 54601
(608) 782-2943

Patient Case Information

Today's Date _____

Name _____ Address _____
City _____ State _____ Zip _____
Age _____ Birth date _____ Your SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____
Number of preference for contact: Home Work Cell
Email Address: _____

Marital status: S M W D No. of Children _____
Are you a student? Y N Full time Y N Part time Y N
Employer _____ Occupation _____
Years on job _____

Insurance Company _____
Primary Care Physician _____ Primary Care Facility _____

Name of spouse or parent _____

IN CASE OF EMERGENCY PLEASE CONTACT: (Name of relative or close friend):

NAME _____

ADDRESS: _____ PHONE: _____

Referred to our office by: _____

PRIVACY NOTICE

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and the coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature _____ Date _____