PATRICK A. TRIBBLE CHIROPRACTIC, INC.

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Patrick A. Tribble, D.C. **Joshua Silver, D.C.**

Patient Health Questionnaire

Patient Name: _____ Date_____/_____/_____

When did your symptoms first occur? _____ Describe your symptoms and how they began: _____

_____

_____

How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

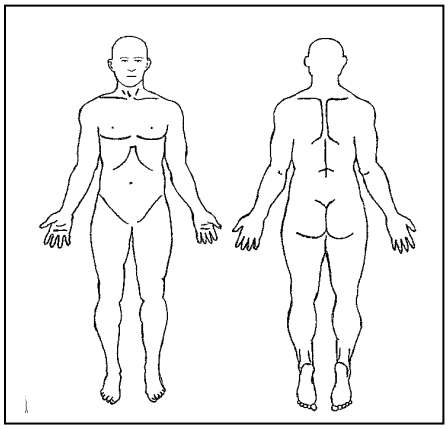
What describes the nature of your symptoms?

- ❑ Sharp ❑ Shooting
- ❑ Dull Ache ❑ Burning
- ❑ Numb ❑ Tingling

How are your symptoms changing?

- ❑ Getting Better
- ❑ Not Changing
- ❑ Getting Worse

Indicate where you have pain or other symptoms on the drawing below.



Indicate the severity of your symptoms (0 = No Pain, 10 = Unbearable):

Worst: 0 1 2 3 4 5 6 7 8 9 10
Best: 0 1 2 3 4 5 6 7 8 9 10

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

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

Who have you seen for your symptoms? _____

Chiropractor Body worker Physical Therapist Medical Doctor Other:

When and what treatment? _____

What tests have you had for your symptoms and when were they performed? Facility: _____

X-Ray Date: _____ CT Scan Date: _____ MRI Date: _____

Have you had similar symptoms in the past? ☐ YES ☐ NO

If you have received treatment in the past for the same or similar symptoms, whom did you see? _____

This Office Other Chiropractor Body Worker Physical Therapist Medical Doctor

What is your occupation?

- ❑ Clerical/Data Entry ❑ Homemaker ❑ Laborer ❑ Professional/Executive ❑ Retired
- ❑ Sales ❑ Secretarial ❑ Student ❑ Tradesperson ❑ Other:

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

- ❑ Explanation of condition/treatment ❑ Learn how to prevent this from happening again ❑ Reduce Symptoms
- ❑ Resume/increase activity ❑ Learn how to take care of this on my own ❑ Other:

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What type of regular exercise do you perform? How Frequently? _____

❑ Aerobics ❑ Bicycling ❑ Jogging/Running ❑ Swimming ❑ Weight Training ❑ Yoga/Pilates

❑ Sports: _____ ❑ Other: _____

What is your height and weight? Height _____ (ft./in.) 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 currently have a condition listed below, place a check in the **Present** column.

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	High Cholesterol	❑	❑	Diabetes
❑	❑	Neck Pain/Stiffness	❑	❑	High Blood Pressure	❑	❑	Excessive Thirst
❑	❑	Jaw Pain/Stiffness	❑	❑	Heart Attack	❑	❑	Frequent Urination
❑	❑	Upper Back Pain	❑	❑	Chest Pains			
❑	❑	Shoulder Pain	❑	❑	Stroke	❑	❑	Smoke/Use Tobacco
❑	❑	Elbow/Upper Arm Pain	❑	❑	Angina	❑	❑	Drug/Alcohol Dependence
❑	❑	Wrist/Hand Pain				❑	❑	Depression
❑	❑	Mid Back Pain	❑	❑	Asthma	❑	❑	Difficulty Sleeping
❑	❑	Low Back Pain	❑	❑	Chronic Sinusitis			
❑	❑	Hip/Upper Leg Pain	❑	❑	Chronic Cough	❑	❑	Allergies
❑	❑	Knee/Lower Leg Pain	❑	❑	Lung Infection	❑	❑	Bruise Easily
❑	❑	Ankle/Foot Pain	❑	❑	Difficulty Breathing	❑	❑	Parkinson's Disease
						❑	❑	Epilepsy/Seizures
❑	❑	Nerve Pain	❑	❑	Kidney Stones	❑	❑	Multiple Sclerosis
❑	❑	Joint Swelling/Stiffness	❑	❑	Kidney Disorders	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Arthritis	❑	❑	Bladder/Kidney Infection			
❑	❑	Rheumatoid Arthritis	❑	❑	Painful Urination		**Females Only**	
❑	❑	Lupus	❑	❑	Loss of Bladder Control	❑	❑	Birth Control Pills
❑	❑	Osteoporosis				❑	❑	Hormonal Replacement
						❑	❑	# of Pregnancies _____
❑	❑	Muscular Uncoordination	❑	❑	Abnormal Weight Gain/Loss			# Carried to Term _____
❑	❑	Visual Disturbances	❑	❑	Loss of Appetite	❑	❑	Premenstrual Syndrome
❑	❑	Dizziness	❑	❑	Prostate Problems	❑	❑	Hysterectomy
❑	❑	General Fatigue	❑	❑	Abdominal Pain/Nausea			
❑	❑	Frequent Colds	❑	❑	Ulcer	❑	❑	**Other Health Problems (Please List):**
			❑	❑	Hepatitis			
❑	❑	Cancer	❑	❑	Liver/Gall Bladder Disorder			
❑	❑	Tumor	❑	❑	Constipation/ Diarrhea			
❑	❑	HIV/AIDS	❑	❑	Gastric Reflex/GERD'S			

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

❑ Cancer ❑ Diabetes ❑ Disc Disease ❑ Heart Disease ❑ Lupus ❑ Rheumatoid Arthritis ❑ Thyroid Disorder ❑ Other

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:

List all surgeries and hospitalizations and when they occurred:

Patient Signature: _____ Date: _____

Doctor's Additional Comments:

Doctor's Signature: _____ Date: _____