EPIC Medical Clinic Chiropractic
PATIENT HEALTH QUESTIONNAIRE

Name: _____ **D.O.B.**_____ **Today's Date:** _____

Person who referred you to our clinic?

❍ Doctor _____ ❍ Patient _____ ❍ Website_____ __ Other_____

A) Tell us about your symptoms

- What are your current symptoms? _____

  _____
- Have you had any recent injury / trauma? ❍ No ❍ Yes _____
- How long have you had these symptoms? _____
- Is the pain mostly in? ❍ Neck ❍ Shoulder ❍ Upper back ❍ Mid back ❍ Low back ❍ Pelvis ❍ Hip ❍ Buttocks ❍ Thigh ❍ Knee ❍ Lower leg ❍ Other_____
- How did these symptoms begin? ❍ Sudden (acute) ❍ Gradual (chronic)
- Is your pain? ❍ Constant (100%) ❍ Frequent (75%) ❍ Occasional (50%) ❍ Intermittent (25% or less)
- Timing of pain occurs? ❍ In the morning ❍ In the evening ❍ After work ❍ Woke up from sleep
- Describe your pain: ❍ Dull ache ❍ Sharp/ Shooting ❍ Stabbing ❍ Burning ❍ Throbbing
- Does the pain radiate? ❍ No ❍ Yes _____
- How do these symptoms limit you? _____
- How severe is your pain? **(in a scale of 0 – 10, 0 is no pain and 10 is *extreme* pain)**

  ❍ No pain (**0**) ❍ Mild (**1, 2, 3**) ❍ Moderate (**4, 5, 6**) ❍ Severe (**7, 8, 9, 10**)
- Do you have weakness or numbness in your arm(s) and or leg(s)? ❍ No ❍ Yes_____
- What makes your pain better? ❍ Rest ❍ Ice ❍ Heat ❍ Pills ❍ Other _____
- Which activities make your pain worst? ❍ Sitting ❍ Standing ❍ Walking ❍ Bending ❍ Lying down ❍ Other _____

B) Tell us about previous treatments and tests you've had

- Have you seen a doctor for your condition? ❍ No ❍ Yes _____
- What treatments did you have? _____
- What tests have you had? ❍ X-ray ❍ MRI ❍ CT scan ❍ EMG ❍ Other _____
- Are you taking any medication for your condition ❍ No ❍ Yes _____
- Did you have any injections for your condition? ❍ No ❍ Yes _____
- Did these injections help? ❍ No ❍ Yes _____
- Did you have PT before for your condition? ❍ No ❍ Yes _____
- Did this therapy help? ❍ No ❍ Yes _____
- Are you taking any medications for any reason? ❍ No ❍ Yes _____
- Are you under any other physician care? ❍ No ❍ Yes _____
- Have you been hospitalized in the past 5 years? ❍ No ❍ Yes _____

- Have you had any major surgery? ❍ No ❍ Yes _____
- Are you allergic to medication or food? ❍ No ❍ Yes _____

C) Tell us about your health

A. YOUR FAMILY HISTORY: Do any of your family members have a history of:

Diabetes	❍ No ❍ Yes	_____
High blood pressure	❍ No ❍ Yes	_____
Heart attack / stroke	❍ No ❍ Yes	_____
Cancer	❍ No ❍ Yes	_____
Arthritis / Joint pain	❍ No ❍ Yes	_____

B. YOUR MEDICAL HISTORY ❑ **None apply**

❍ Anemia	❍ Epilepsy	❍ Muscle disease
❍ Asthma	❍ Heart attack	❍ Osteoporosis
❍ Blood clot in leg	❍ High blood pressure	❍ Stomach problem
❍ Bleeding disorder	❍ Kidney disease	❍ Thyroid problem
❍ Cancer	❍ Liver problem	❍ Other: _____
❍ Diabetes	❍ Migraines or headaches	

C. SOCIAL HISTORY

1. Marital status:	❍ Single	❍ Married	❍ Divorced	❍ Widowed
2. Work Status:	❍ Homemaker	❍ Working	❍ Retired	❍ Student
3. Children	❍ No	❍ Yes #_____		
3. Tobacco:	❍ Never	❍ Cigarettes _____	packs/day for _____	
	❍ Quit, when?_____			
4. Exercise:	❍ Never	❍ Rarely	❍ Weekly	❍ Daily
	What type of exercise? _____			
5. Drink Alcohol:	❍ Never	❍ Social / Occasion	❍ _____ Drink/wk	

D. REVIEW OF SYSTEMS (check all that apply): ❑ None apply

❑ Reading glasses	❑ Toothache	❑ Frequent Headaches
❑ Change of vision	❑ Gum trouble	❑ Blackouts
❑ Loss of hearing	❑ Nausea or vomiting	❑ Seizure
❑ Stomach pain	❑ Frequent rash	❑ Ulcer
❑ Hot or cold spells	❑ Nosebleeds	❑ Frequent belching
❑ Difficulty swallowing	❑ Frequent diarrhea	❑ Recent weight change
❑ Morning coughs	❑ Frequent Constipation	***Women Only:***
❑ Shortness of breath	❑ Hemorrhoids	❑ Irregular periods
❑ Fever or chills	❑ Frequent urination	❑ Vaginal discharge
❑ Chest pains	❑ Burning on urination	❑ Frequent spotting
❑ Abnormal heartbeat	❑ Swollen ankles	❑ Other: _____