UNFRIED
CHIROPRACTIC AND ACTIVE RELEASE TECHNIQUE CLINIC

Patient Health Questionnaire

Please print this page, complete the form, and bring to your appointment

Patient Name _____ **Date** _____

Describe your symptoms _____

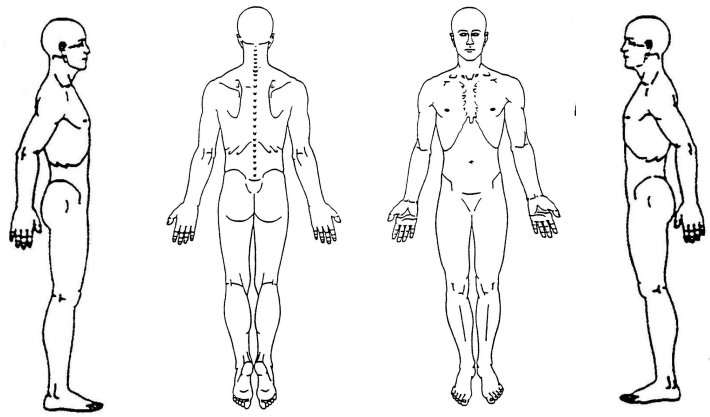
- **When did your symptoms start?** _____
- **How did your symptoms begin?** _____

How often do you experience your symptoms?
1. Constantly (76-11% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50% of the day)
4. Intermittently (0-25% of the day)

What describes the nature of your symptoms?
1. Sharp
2. Dull Ache
3. Numb
4. Shooting
5. Burning
6. Tingling

How are your symptoms changing?
1. Getting better
2. Not changing
3. Getting worse

Indicate where you have pain or other symptoms



During the last 4 weeks, indicate the average intensity of your symptoms: 1 being ***None*** and 10 being ***Unbearable***

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

During the last 4 weeks, how much has pain interfered with your normal work (outside and inside of the home)
1. Not at all. 2. A little bit. 3. Moderately. 4. Quite a bit. 5. Extremely.

During the last 4 weeks, how much of the time has your condition interfered with your social activities?
1. All of the time. 2. Most of the time. 3. Some of the time. 4. A little of the time. 5. None of the time.

In general, would you say your overall health right now is....
1. Excellent. 2. Very Good. 3. Good. 4. Fair. 5. Poor.

Who have you seen for your symptoms?
1. No one 2.Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

- **What treatment did you receive and when?** _____
- **What tests have you had for your symptoms and when were they performed?**

1. X-Ray (date: _____) 2. MRI (date:_____) 3. CT Scan (date:_____) 4. Other

Have you had similar symptoms in the past? Yes No

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

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

What is your occupation? _____

- 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

Patient Signature _____ **Date** _____