Puritz Chiropractic Center
Patient Health Questionnaire

PERSONAL INFORMATION

Today's Date: ________________ File #:________________

First Name: ______________________________ Middle Initial: _____ Last Name: ______________________________________

Preferred First Name / Nickname: _________________________ Social Security #:____________-______-____________

Are you: ❒ right handed ❒ left handed ❒ ambidextrous Date of Birth: _____/_____/_____ Age: __________

Address: ____

City: ______________________________________ State: _____________ Zip: _______________

Phone: ( ) __________-__________ Work: ( ) __________-__________ext.______

Cell: ( ) __________-__________ Email:____

Occupation: ____________________________________ Employer: ____

Business Address: ____

Marital Status: S M D W Sex: M F Name of Spouse: ____

Ages & Names of Children: ____

Who Referred You To Our Office Or How Did You Hear About Us? ____

Have You Had Previous Chiropractic Care? ❒ No ❒ Yes; if so please indicate when and the doctors name: __________________

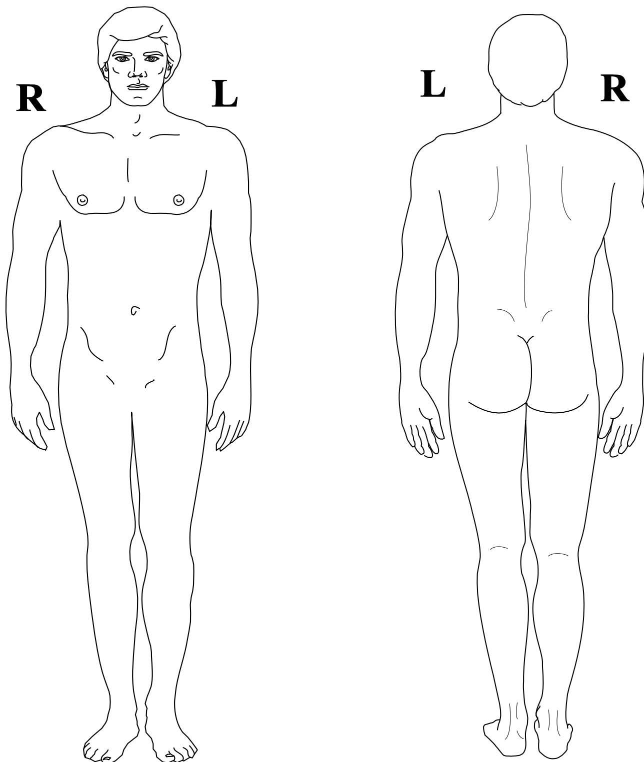
____

____

Date of Your Last Physical Examination: _____/_____/_____

CURRENT COMPLAINTS

Pain Drawing: Please mark where and what type of pain you are currently experiencing. Use the symbols indicated to describe the type of pain or sensations you are feeling:



Use these symbols to describe the type of pain or sensations you are feeling:

>>>	**Aching pain**
///	**Stabbing or Sharp pain**
XXX	**Burning pain**
===	**Numbness**
ooo	**Pins and Needles**

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Please list your complaints below with the most significant or primary complaint first:

1. **Area of Pain**: ________________ **Frequency**: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
   Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

   The pain is aggravated by: ________________

   The pain is relieved by: ________________

2. **Area of Pain**: ________________ **Frequency**: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
   Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

   The pain is aggravated by: ________________

   The pain is relieved by: ________________

3. **Area of Pain**: ________________ **Frequency**: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
   Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

   The pain is aggravated by: ________________

   The pain is relieved by: ________________

4. Other: ________________

In general my symptoms are worse in: ❒ AM ❒ Midday ❒ PM; ❒ my symptoms do not change with the time of day.

Are your symptoms / condition: ❒ improving ❒ unchanged ❒ getting worse

HISTORY

Symptoms developed from: ❒ work injury ❒ car accident ❒ sports injury ❒ lifting/fall ❒ gradual ❒ unknown

The pain began on or about: ________________. The pain is chronic and originally began on or about: ________________

Describe how the symptoms began or what you think caused the symptoms / condition: ________________

List other doctors you have seen for this complaint, the type of treatment given, and the result of that treatment: ________________

Describe any past history of the same or similar complaint: ________________

MEDICAL HISTORY

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CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

❒ Blurring vision
❒ Dizziness
❒ Loss of bowel or bladder function
❒ Constipation
❒ Diarrhea
❒ Rectal bleeding
❒ Allergies

❒ Buzzing or ringing in ears
❒ Numbness
❒ Confusion
❒ Loss of sleep
❒ Stomach difficulty
❒ Frequent urination
❒ Frequent colds
❒ Asthma

❒ Headaches: Area of head:____________________
How often: ❒ daily ❒ ____ times per day
❒ ____ times per week ❒ ____ times per month

❒ Chest pains
❒ Painful urination
❒ Difficulty swallowing
❒ Cancer:(Type)_________________________

Do you have a pacemaker? ❒ Yes ❒ No

Please list any serious illness or medical conditions you have had and associated treatment**:**

____
____
____
____

Please list the name and address of your primary care physician & any specialist you have seen**:**

____
____
____
____

SURGICAL HISTORY

Please list any surgeries you have had; include date, type of surgery or for what condition and outcome:

____
____
____
____

FAMILY HISTORY

Please list any family history of heart disease, cancer, diabetes or other serious illness:

____
____
____

Women Only

Important - if you suspect you are currently pregnant, please notify the doctor immediately. X-rays should not be taken if you are pregnant!

Are you pregnant? ❒ Yes ❒ No Date of last menstrual cycle: _________________________ Do you have PMS? ❒ Yes ❒ No

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WORK HISTORY

How many hours do you normally work in a week? _____________ Are you currently not working? ❐ Yes ❐ No

In a typical workday, I (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

On the job, I perform the following activities: In terms of an 8-hour workday, "occasionally" = 33%, "frequently" = 34% to 66%, and "continuously" = 67% to 100% of the day.

	Not At All	Occasionally	Frequently	Continuously
Bend / Stoop	❐	❐	❐	❐
Squat	❐	❐	❐	❐
Crawl	❐	❐	❐	❐
Climb	❐	❐	❐	❐
Reach above shoulder level	❐	❐	❐	❐
Crouch	❐	❐	❐	❐
Kneel	❐	❐	❐	❐
Balancing	❐	❐	❐	❐
Pushing / Pulling	❐	❐	❐	❐

Check the category that best describes your work:

❐ **Sedentary:** Lifting up to 10 lbs. maximum and occasionally lifting and / or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking is required only occasionally and other sedentary criteria are met.

❐ **Light Work:** Lifting 20 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 10 lbs. Even though the weight lifting may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling or arm and / or leg controls.

❐ **Medium Work:** Lifting 50 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 25 lbs.

❐ **Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 50 lbs.

❐ **Very Heavy Work:** Lifting objects in excess of 100 lbs. with frequent lifting and / or carrying of objects weighing 50 lbs. or more.

SOCIAL HISTORY

Do you smoke? ❐ N o ❐ Yes; if yes, how many packs of cigarettes do you smoke per day? ____________________

How many cups of coffee or caffeinated drinks do you have per day? __________

Do you consume alcohol? ❐ No ❐ Yes; if yes, would you say that your use of alcohol is ❐ occasional ❐ frequent or ❐ daily. Would you say your consumption of alcohol is ❐ light, ❐ medium, or ❐ heavy?

Do you have a regular program of exercise? ❐ No ❐ Yes, if yes, please note the frequency and type of exercise that you do:

____

____

List any hobbies or recreational sports / activities you enjoy doing:

____

____

____

Fill This Section Out If Your Injury Is Related To an Automobile Accident

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Date of accident: _______________________ Hour: ______________ ❒ AM ❒ PM

Were you the ❒ driver ❒ passenger: ❒ front seat ❒ back seat; ❒ pedestrian. Were the roads ❒ dry ❒ wet ❒ snowy.

Were you struck from ❒ behind ❒ driver's side ❒ passenger's side ❒ head on. Were you wearing a seat belt ❒ Yes ❒ No

Do you recall any part of your head or body striking any part of the interior of the car? ❒ Yes ❒ No

If yes, please describe: ____

____

Type of vehicle you were in? _______________________________ Type of vehicle that struck you? ______________________________

Head / body position at time of impact:

❒ head turned to left / right ❒ head looking back ❒ head straight forward

❒ body straight in sitting position ❒ body rotated to left / right ❒ other:______________________________

Did you feel pain ❒ immediately ❒ gradually ❒ next day ❒ other: ____

Were you knocked unconscious? ❒ Yes ❒ No. Did you receive first aid? ❒ Yes ❒ No

Did you go to the hospital by ❒ ambulance, ❒ a friend, or did you ❒ drive yourself.

Name of hospital: ____

Did the hospital take x-rays? ❒ Yes ❒ No. What treatment was given? ____

____

____

Have you been unable to work because of the accident? ❒ No ❒ Yes; if yes since when: _____/_____/_____

Have you consulted an attorney? ❒ No ❒ Yes; if yes please give name, address, and phone: _________________________________

____

____

Fill This Section Out If Your Injury Is Related To a Work Accident

Date of accident: _____/_____/_____ Hour: ______________ ❒ AM ❒ PM

Did you report the accident to your supervisor within 48 hours? ❒ Yes ❒ No

Did a fellow employee witness the accident? ❒ Yes ❒ No

Have you been unable to work because of the accident? ❒ No ❒ Yes; if yes since when: _____/_____/_____

Have you consulted an attorney? ❒ No ❒ Yes; if yes please give name, address, and phone: _________________________________

____

____

Patient’s Signature: ____ Date: _____/_____/_____

(or guardian if child)