Sheldon Road Chiropractic
& Massage Therapy

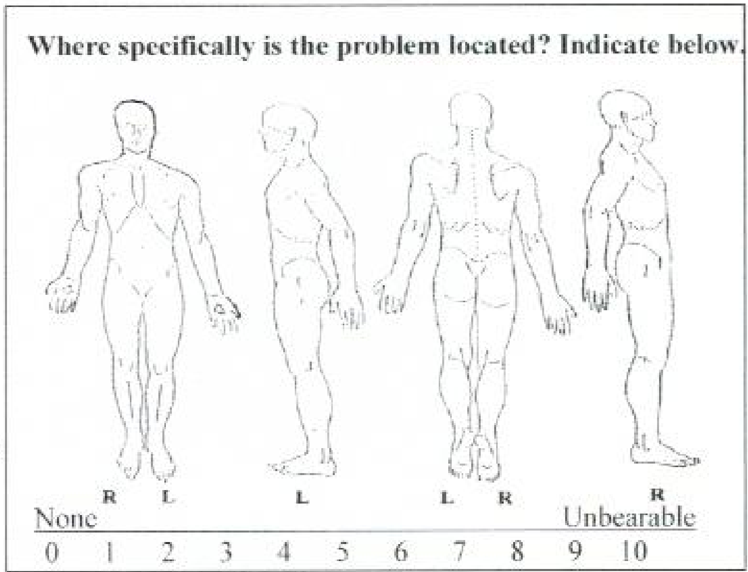
Patient Health Questionnaire

Patient Name: ________________________________ Date: ______________

1. Describe your symptoms: ________________________________
   a. When did your symptoms start? ________________________________
   b. How did your symptoms begin? ________________________________

2. 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)

Where specifically is the problem located? Indicate below.



None — Unbearable

0 1 2 3 4 5 6 7 8 9 10

3. What describes the nature of your symptoms?

□ Sharp □ Shooting □ Tingling
□ Dull ache □ Burning □ Numbness
□ Throbbing □ Stiffness □ Swelling

4. How are your symptoms changing?

□ Getting better □ Not changing □ Getting worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms:

b. How much has pain interfered with your normal work (both work outside the home and housework)

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

6. Which activities are difficult to perform: □ sitting □ standing □ walking □ bending □ laying down □ other ____________

7. During the past 4 weeks, how much of the time has your condition interfered with your daily activities?

□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

8. In general would you say your overall health right now is…

□ Excellent □ Very good □ Good □ Fair □ Poor

9. Who have you seen for your symptoms? □ No one □ Other Chiropractor □ Medical Doctor □ Physical Therapist □ Other

a. What treatment did you receive and when? ________________________________

b. What test have you had for you symptoms and when were they performed? □ X-rays date:__________ □ CT scan date:__________ □ MRI date:__________ □ Other date:__________

c. Name and address of other doctors who have treated you for this condition: ________________________________

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10. Have you had similar symptoms in the past? □ Yes □ No **If yes when:**______________________

a. If you have received treatment in the past for the same or similar symptoms, who did you see? □ This Office □ Medical Doctor □ Other □ Other Chiropractor □ Physical Therapist

11. What is your occupation? □ Professional/Executive □ Laborer □ Retired □ Tradesperson □ White collar/Secretarial □ Homemaker □ FT student □ Other

X (SIGNATURE OF PATIENT or parent if minor) **DATE:**