

**Patient Health Questionnaire - page 2**

American Chiropractic Network

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What type of regular exercise do you perform? 1)None 2)Light 3)Moderate 4)Strenuous

What is your height and weight? Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.  
Feet Inches

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 presently have a condition listed below, place a check in the Present column.

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
___	___	Headaches	___	___	High Blood Pressure	___	___	Diabetes
___	___	Neck Pain	___	___	Heart Attack	___	___	Excessive Thirst
___	___	Upper Back Pain	___	___	Chest Pains	___	___	Frequent Urination
___	___	Mid Back Pain	___	___	Stroke	___	___	Smoking/Use Tobacco Products
___	___	Low Back Pain	___	___	Angina	___	___	Drug/Alcohol Dependence
___	___	Shoulder Pain	___	___	Kidney Stones	___	___	Allergies
___	___	Elbow/Upper Arm Pain	___	___	Kidney Disorders	___	___	Depression
___	___	Wrist Pain	___	___	Bladder Infection	___	___	Systemic Lupus
___	___	Hand Pain	___	___	Painful Urination	___	___	Epilepsy
___	___	Hip/Upper Leg Pain	___	___	Loss of Bladder Control	___	___	Dermatitis/Eczema/Rash
___	___	Knee/Lower Leg Pain	___	___	Prostate Problems	___	___	HIV/AIDS
___	___	Ankle/Foot Pain	___	___	Abnormal Weight Gain/Loss	___	___	
___	___	Jaw Pain	___	___	Loss of Appetite	___	___	<b>Females Only</b>
___	___	Joint Swelling/Stiffness	___	___	Abdominal Pain	___	___	Birth Control Pills
___	___	Arthritis	___	___	Ulcer	___	___	Hormonal Replacement
___	___	Rheumatoid Arthritis	___	___	Hepatitis	___	___	Pregnancy
___	___	General Fatigue	___	___	Liver/Gall Bladder Disorder	___	___	
___	___	Muscular Incoordination	___	___	Cancer	___	___	<b>Other Health Problems/Issues</b>
___	___	Visual Disturbances	___	___	Tumor	___	___	_____
___	___	Dizziness	___	___	Asthma	___	___	_____
___	___		___	___	Chronic Sinusitis	___	___	_____

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

\_\_\_ Rheumatoid Arthritis \_\_\_ Heart Problems \_\_\_ Diabetes \_\_\_ Cancer \_\_\_ Lupus \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

List all the surgical procedures you have had and times you have been hospitalized:

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Additional Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_