ALL STAR HEALTH
SPINE & SPORTS CARE

PATIENT HEALTH QUESTIONNAIRE

NAME ______________________________ **DATE** ___/___/___

In the space below, please describe your major complaint.
If you have an additional complaint, please describe on page 2

1. Please Describe your Complaint: ______________________________

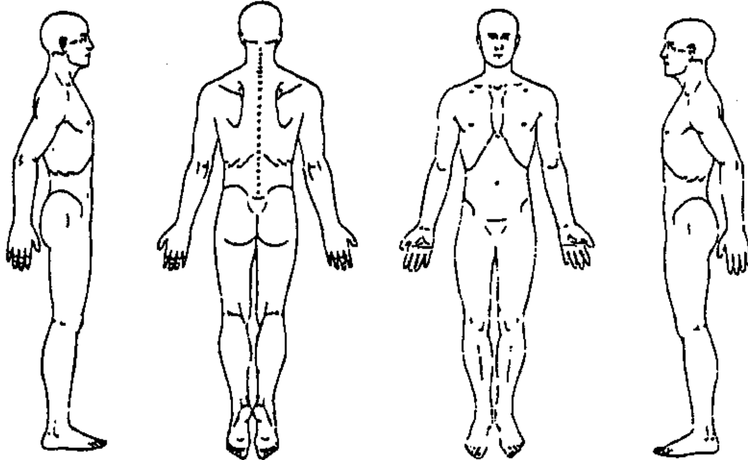
a. Description

☐ Sharp Pain
☐ Dull Pain
☐ Ache
☐ Weak
☐ Throbbing
☐ Numb
☐ Shooting
☐ Gripping
☐ Burning
☐ Tingling

b. Frequency

☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (1-25%)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



c. Indicate intensity of your pain at its lowest and highest level **No Pain** [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] **Unbearable Pain**

d. Your symptoms are ☐ decreasing ☐ not changing ☐ increasing

e. Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day

2. Date Problem Began: ______________ Describe how your problem began: ______________

3. Have you ever been treated *for this episode?* ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other ______
Are you currently being seen? ☐ Yes ☐ No
When and what treatment?___/___/___

4. ***In the past*** have you ever been treated for the same or a similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other ______
When and what treatment did you receive? ______

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

7. How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

8. General Physical Activity: ☐ No regular Exercise program ☐ Light Exercise program ☐ Moderate Exercise program ☐ Strenuous Exercise program

9. Are your complaints affecting your ability to be active?
☐ No effect
☐ Need limited assistance with common everyday tasks.
☐ Have a significant inability to function without assistance.
☐ Some physical restrictions (able to perform light duty work and household tasks).
☐ Need assistance often.
☐ Am totally disabled (impaired). Cannot care for self.

10. Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion

11. Occupation: ______________ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No

12. What is your current work status?
[1] Full time, no restrictions.
[2] Full time, with restrictions.
[3] Part time, with no restrictions.
[4] Part time, with restrictions.
[5] Off work due to restrictions.
[6] Full time homemaker.
[7] Unemployed.
[8] Retired.
[9] Full time student.
[10] Other: ______________

PLEASE CONTINUE ON PAGE 2.

Patient Signature: ______________________________ **Date:** ___/___/___

MEDICAL HISTORY - REVIEW OF SYMPTOMS
CHECK SYMPTOMS/CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST

CONSTITUTIONAL
O LOSS OF APPETITE O FEVER O FATIGUE O WEIGHT
O NIGHT SWEATS O NAUSEA O VOMITING O CHILLS

CARDIOVASCULAR
O HYPERTENSION O CHEST PAIN O MURMUR
O HEART ATTACK O PACEMAKER O STROKE
O HIGH CHOLESTEROL O CLAUDICATION
O RAPID HEART BEAT

RESPIRATORY
O ASTHMA O DIFFICULTY BREATHING
O SLEEP APNEA O EMPHYSEMA O WHEEZING
O COUGH O SHORTNESS OF BREATH

GENITOURINARY
O KIDNEY STONES O BLADDER INFECTION
O PAINFUL URINATION O LOSS OF BLADDER CONTROL
O FREQUENT URINATION O KIDNEY DISORDERS
O URINARY TRACT INFECTION

SKIN
O RASH O ECZEMA O ACNE O PSORIASIS
O BREAST PAIN

PSYCHIATRIC
O ANXIETY O PANIC ATTACK O DEPRESSION O ADDICTION

ALLERGIC/IMMUNOLOGIC
O ALLERGIES O ITCHY EYES O SNEEZING
O RUNNY NOSE

EYES
O VISUAL DISTURBANCES O CONTACTS O GLASSES
O BLURRED VISION O CATARACTS O GLAUCOMA

EARS/NOSE/MOUTH/THROAT
O TINNITUS O RECURRING EAR INFECTIONS
O CHRONIC SINUSITIS O LOSS OF HEARING O JAW PAIN

GASTRONINTESTINAL
O ULCER O HEARTBURN O ABDOMINAL PAIN
O CONSTIPATION O LIVER PROBLEMS O DIARRHEA
O GALL BLADDER O DIFFICULTY SWALLOWING
O ACID REFLUX O HIATAL HERNIA

MUSCULOSKELETAL
O ARTHRITIS O RHEUMATOID ARTHRITIS O MUSCLE PAIN
O NECK PAIN O BACK PAIN O SHOULDER PAIN
O JOINT PAIN O FIBROMYALGIA O KNEE PAIN
O WRIST PAIN O FOOT PAIN O ARM PAIN
O GOUT O STIFFNESS O WEAKNESS
O BURSITIS O TENDONITIS O CARPAL TUNNEL

NEUROLOGICAL
O EPILEPSY O DIZZINESS O SEIZURES O SYNCOPE
O CONFUSION O VERTIGO O HEADACHE O TREMOR
O LOSS OF BALANCE O NUMBNESS O SLURRED SPEECH
O DIFFICULTY/CHANGE IN HANDWRITING

ENDOCRINE
O EXCESSIVE THIRST O FREQUENT URINATION
O ABNORMAL WEIGHT GAIN O ABNORMAL WEIGHT LOSS
O THYROID PROBLEMS O DIABETES

HEMATOLOGICAL/LYMPHATIC
O BLOOD DISORDER O CANCER O HIV/AIDS O TUMOR

FEMALE ONLY
O CURRENTLY PREGNANT O HORMONE REPLACEMENT
O ENDOMETRIOSIS O IRREGULAR MENSTRUAL FLOW
O PMS O PROFUSE MENSTRUAL FLOW
O INFERTILITY O TUBAL LIGATION
O MISCARRIAGE O MENOPAUSE

MALE ONLY
O ERECTILE DYSFUNCTION O PROSTATE PROBLEMS
O INFERTILITY O VASECTOMY

ALLERGIES
O NONE O MEDICATION O SEASONAL O FOOD O ANIMALS

FAMILY HISTORY
O CANCER O UNKNOWN
O RHEUMATOID ARTHRITIS O EPILEPSY
O DIABETES O CHRONIC BACK PROBLEMS
O HEART PROBLEMS O CHRONIC HEADACHES
O LUNG PROBLEMS O LUPUS
O STROKE O HIGH BLOOD PRESSURE
O ______________________

MEDICATIONS O NONE
1.
2.
3.
4.
5.

HOSPITALIZATIONS/FRACTURES O NONE
1.
2.
3.
4.

SURGERIES O NONE
O TONSIL/ADENOIDS O HEART O NECK
O APPENDIX O C-SECTION O LOW BACK
O GALL BLADDER O HYSTERECTOMY O ____________

SOCIAL HABITS

O SMOKE	0	1/2	1	2	>2		PACKS/DAY
O DRINK ALCOHOL	0	1-3	4-7	>7			DRINKS/WEEK
O CAFFEINE	0	1-3	4-6	>6			CUPS/DAY
O CHILDREN	0	1	2	3	4	5	6 OTHER
O DRUG DEPENDENCE							

EDUCATION (HIGHEST LEVEL COMPLETED)
O NONE O ELEMENTARY O JR. HIGH O HIGH SCHOOL O COLLEGE

DIET (MARK FREQUENTLY CONSUMED FOODS)
O BREAD O PASTA O CEREAL O FRUITS
O POP O COFFEE O WATER O VEGETABLES

VITAMINS/SUPPLEMENTS O NONE
O MULTI-VITAMIN O CO Q 10
O CALCIUM/MAGNESIUM O PROTEOLYTIC ENZYMES
O ESSENTIAL FATTY ACIDS O OTHER______________

SLEEP (AVERAGE HOURS PER DAY) 4 5 6 7 8 9 10 11 12 13

(POSITION) O SIDE O BACK O STOMACH

DATE:______________ HEIGHT:____________ WEIGHT:____________

ADDITIONAL INFORMATION - PATIENT:

PATIENT SIGNATURE______________________________

ADDITIONAL INFORMATION - PHYSICIAN:

PHYSICIAN SIGNATURE______________________________