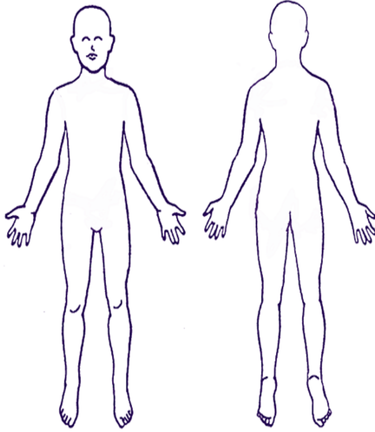
Patient Name:______________________________ Date:_________

Health Questionnaire

Current Complaints:



Pain Locations:
Mark location of pain with numbers in order of significance. Describe pain with corresponding numbers (i.e. "Pain Location 1") on right.

***Ask doctor for additional sheet if you have more than 2 pain locations.**

Doctor Notes:
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Pain Location 1:____________

1.a. When Did Symptoms Start:______
1.b. How did symptoms start?
❑Auto Accident (complete page 3) ❑Work
❑Awoke with pain ❑Unknown
❑Work Accident (complete page 4) ❑Other: ____________
____
____

2. Rate pain on scale: (0=none; 10=unbearable)
0 1 2 3 4 5 6 7 8 9 10

3. Symptoms occur:
❑Constantly (76-100% of day)
❑Frequently (51-75% of day)
❑Occasionally (26-50% of day)
❑Intermittently (0-25% of day)

4. Overall Severity:
❑Mild
❑Mild to Moderate
❑Moderate
❑Moderate to Severe
❑ Severe

5. Nature of symptoms:
❑Sharp ❑Dull ache ❑Shooting
❑Burning ❑Tingling ❑Numb
❑Radiating to ________________

6. How are symptoms changing:
❑ Better ❑ Worse ❑ No change

7. The following make symptoms worse:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑Sneeze/Cough/Laugh
❑ Other ____________________

8. The following makes symptoms better:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑ Pain Medication ________
❑ Other_____________________

9. Pain interferes with:
❑ Work ❑ Hobbies ❑ Recreation
❑ Home ❑ Relationships

Pain Location 2:____________

1.a. When Did Symptoms Start: ______
1.b. How did symptoms start?
❑Auto Accident (complete page 3) ❑Work
❑Awoke with pain ❑Unknown
❑Work Accident (complete page 4) ❑Other: ____________
____
____

2. Rate pain on scale: (0=none; 10=unbearable)
0 1 2 3 4 5 6 7 8 9 10

3. Symptoms occur:
❑Constantly (76-100% of day)
❑Frequently (51-75% of day)
❑Occasionally (26-50% of day)
❑Intermittently (0-25% of day)

4. Overall Severity:
❑Mild
❑Mild to Moderate
❑Moderate
❑Moderate to Severe
❑ Severe

5. Nature of symptoms:
❑Sharp ❑Dull ache ❑Shooting
❑Burning ❑Tingling ❑Numb
❑Radiating to ________________

6. How are symptoms changing:
❑ Better ❑ Worse ❑ No change

7. The following make symptoms worse:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑Sneeze/Cough/Laugh
❑ Other ____________________

8. The following makes symptoms better:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑ Pain Medication ________
❑ Other_____________________

9. Pain interferes with:
❑ Work ❑ Hobbies ❑ Recreation
❑ Home ❑ Relationships

Have you seen other doctors? ❑Yes ❑No If yes, who?______________________________
Have you had similar symptoms in the past? ❑Yes ❑No If yes, explain?____________________
Have you had treatment for these symptoms? ❑Yes ❑No If yes, explain?____________________

Patient Signature ______________________________ **Date**__________

Doctor Notes:____
____
____

Patient Name:________________________________ Date:_________

Supplemental Pain Location Page

Pain Location 3:_____________

1.a. When Did Symptoms Start:_______

1.b. How did symptoms start?

❑Auto Accident (complete page 3) ❑Work
❑Awoke with pain ❑Unknown
❑Work Accident (complete page 4) ❑Other: _______________

____
____

2. Rate pain on scale: (0=none; 10=unbearable)

O 1 2 3 4 5 6 7 8 9 10

3. Symptoms occur:
❑Constantly (76-100% of day)
❑Frequently (51-75% of day)
❑Occasionally (26-50% of day)
❑Intermittently (0-25% of day)

4. Overall Severity:
❑Mild
❑Mild to Moderate
❑Moderate
❑Moderate to Severe
❑ Severe

5. Nature of symptoms:
❑Sharp ❑Dull ache ❑Shooting
❑Burning ❑Tingling ❑Numb
❑Radiating to ___________________

6. How are symptoms changing:
❑ Better ❑ Worse ❑ No change

7. The following make symptoms worse:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑Sneeze/Cough/Laugh
❑ Other _______________________

8. The following makes symptoms better:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑ Pain Medication ❑ Other
❑ Other________________________

9. Pain interferes with:
❑ Work ❑ Hobbies ❑ Recreation
❑ Home ❑ Relationships

Pain Location 4:_____________

1.a. When Did Symptoms Start: ______

1.b. How did symptoms start?

❑Auto Accident (complete page 3) ❑Work
❑Awoke with pain ❑Unknown
❑Work Accident (complete page 4) ❑Other: _______________

____
____

2. Rate pain on scale: (0=none; 10=unbearable)

0 1 2 3 4 5 6 7 8 9 10

3. Symptoms occur:
❑Constantly (76-100% of day)
❑Frequently (51-75% of day)
❑Occasionally (26-50% of day)
❑Intermittently (0-25% of day)

4. Overall Severity:
❑Mild
❑Mild to Moderate
❑Moderate
❑Moderate to Severe
❑ Severe

5. Nature of symptoms:
❑Sharp ❑Dull ache ❑Shooting
❑Burning ❑Tingling ❑Numb
❑Radiating to ___________________

6. How are symptoms changing:
❑ Better ❑ Worse ❑ No change

7. The following make symptoms worse:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑Sneeze/Cough/Laugh
❑ Other _______________________

8. The following makes symptoms better:
❑ Heat ❑ Exercise ❑ Standing
❑ Ice ❑ Sitting ❑ Sleeping
❑ Lifting ❑ Bending ❑ Walking
❑ Pain Medication ❑ Other
❑ Other________________________

9. Pain interferes with:
❑ Work ❑ Hobbies ❑ Recreation
❑ Home ❑ Relationships

Doctor Notes:____
____
____
____
____
____
____

Patient Health Questionnaire – page 3

Patient Name:____ Date: ________________

What type of regular exercise do you perform? ○ **None** ○ **Light** ○ **Moderate** ○ **Strenuous**

What is your height and weight? Height [ ][ ][ ] Feet Inches   Weight [ ][ ][ ] lbs.   Blood Pressure [/]   Pulse [ ]

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.

Past	Present		Past	Present		Past	Present	
		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**			**Chronic Sinusitis**
		Jaw Pain			**Loss of Appetite**	**Females Only**		
		Joint Swelling/ Stiffness			**Abdominal Pain**			**Birth Control Pills**
		Arthritis			**Ulcer**			**Hormonal Replacement**
		Rheumatoid Arthritis			**Hepatitis**			**Pregnancy**
		General Fatigue			**Liver/Gall Bladder Disorder**	**Other Health Problems / Issues**		
		Muscular Incoordination			**Cancer**			**Alocohol use-Social**
		Visual Disturbances			**Tumor**			**Alcohol-None**
		Dizziness			**Asthma**			

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 and their dosages:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Are you allergic to any medications (please list): ________________ ________________ ________________

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

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Patient's Signature ______________________ **Date:**________ **Doctor's Signature** ______________________ **Date:**_____

Consent For Use And/Or Disclosure Of Protected Health Information To Carry Out Treatment, Payment And/Or Healthcare Operations

Through the use of this consent form _______________(referred to as the or this "office") is notifying you and agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.

2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.

3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.

4. The following appointment reminders will be used by this office: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

5. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

6. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.

7. This office is not required to agree to any restrictions on your health information that you have requested.

8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.

9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of a previously signed consent.

10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.

11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice,and all of my questions have been answered to my full satisfaction in a way that I can understand.

________________________________	________________________________
Name of Patient/Individual (Please Print)	Signature of Patient/Individual
________________________________	________________________________
Signature of Legal Representative	Relationship to Patient
________________________________	________________________________
Date Signed	Witness