WELLS CHIROPRACTIC

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1608 10th St, East Moline, IL 61244

PATIENT HEALTH QUESTIONNAIRE

PATIENT SIGNATURE: ________________________________ **DATE:** ____________________

1 *PATIENT INFORMATION*

FULL NAME	______________________________	❑ **MALE** ❑ **FEMALE**	
STREET ADDRESS	______________________	**BIRTHDATE / AGE**	____________
CITY/STATE/ZIP	______________________	**SOCIAL SEC #**	____________
FAMILY PHYSICIAN	______________________	**LAST VISIT DATE**	____________
EMPLOYER	______________________	**WORK HOURS**	____________
OCCUPATION	______________________	**STATE LOCATION**	____________
SPOUSE NAME	______________________	**BIRTHDATE / AGE**	____________
EMPLOYER	______________________	**SOCIAL SEC #**	____________

2 *CONTACT INFORMATION*

CONTACT NUMBERS:

CELL PHONE	______________________
HOME PHONE	______________________
WORK PHONE	______________________
REFERRED BY	______________________

MAY WE LEAVE A MESSAGE?

CELL PHONE	❑ **YES**	❑ **NO**
HOME PHONE	❑ **YES**	❑ **NO**
WORK PHONE	❑ **YES**	❑ **NO**

3 *INSURANCE INFORMATION*

WHO IS RESPONSIBLE FOR MY TREATMENT?

❑ **CASH / NO INSURANCE**

❑ **INSURANCE** (Please give Insurance Card to front desk)

❑ **AUTO ACCIDENT** (Please ask for appropriate forms at front desk)

❑ **WORKERS COMPENSATION** (Please ask for appropriate forms at front desk)

4 *CURRENT CONDITION INFORMATION*

WHAT PROBLEM/PAIN BROUGHT YOU TO OUR OFFICE? ______________________________

WHEN AND HOW DID IT START? ______________________________

____

IS THIS AN INJURY? YES:	❑ Auto accident	❑ Workers comp	❑ Home	❑ Other
NO:	❑ Just started	❑ Had for some time	❑ Occurs off and on	
MY PROBLEM/PAIN IS:	❑ Getting worse	❑ Staying the same	❑ Getting better	
DESCRIBE PROBLEM/PAIN:	❑ Sharp ❑ Dull	❑ Burning ❑ Numb	❑ Shooting	❑ Stiff
IT INTERFERS WITH:	❑ Home activities	❑ Work activities	❑ Recreational activities	
TREATMENT SO FAR:	❑ None	❑ Family MD	❑ Physical Therapist	
	❑ Orthopedic	❑ Chiropractor	❑ Medication	
FREQ OF PROBLEM/PAIN:	❑ Intermittently (1-25%)	❑ Occasionally (26-50%)		
	❑ Frequently (51-75%)	❑ Constantly (76-100%)		

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS FOR YOUR CURRENT PROBLEM/PAIN?

Test	Date	Results	Prescribing Doctor
MRI	Date: ________	Results: ________	Prescribing Doctor: ________
X-RAYS	Date: ________	Results: ________	Prescribing Doctor: ________
CT SCAN	Date: ________	Results: ________	Prescribing Doctor: ________
NEURO/ORTHO	Date: ________	Results: ________	Prescribing Doctor: ________

DOES YOUR PROBLEM/PAIN INCREASE OR DECREASE DURING THE FOLLOWING ACTIVITIES?

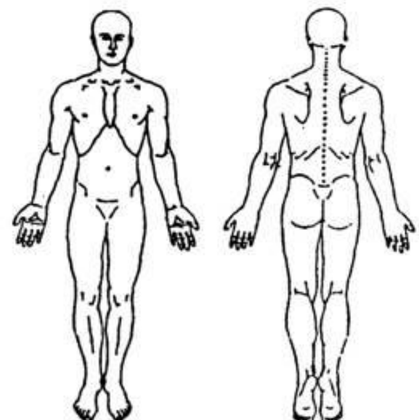
Activity			
Lifting:	❑ Increase	❑ Decrease	❑ Neither
Sitting:	❑ Increase	❑ Decrease	❑ Neither
Exercise:	❑ Increase	❑ Decrease	❑ Neither
Standing:	❑ Increase	❑ Decrease	❑ Neither
Turning Head:	❑ Increase	❑ Decrease	❑ Neither
Going Up Stairs:	❑ Increase	❑ Decrease	❑ Neither
Bending Forward:	❑ Increase	❑ Decrease	❑ Neither
Looking Up/Down:	❑ Increase	❑ Decrease	❑ Neither
Going Down Stairs:	❑ Increase	❑ Decrease	❑ Neither
Moving Neck/Back:	❑ Increase	❑ Decrease	❑ Neither
Rising From Sitting:	❑ Increase	❑ Decrease	❑ Neither
Changing Positions:	❑ Increase	❑ Decrease	❑ Neither
Coughing/Sneezing:	❑ Increase	❑ Decrease	❑ Neither

HOW BAD IS YOUR PROBLEM/PAIN?

0 = No Pain Severe Pain = 10

0 1 2 3 4 5 6 7 8 9 10

PLEASE SHADE IN AREA(S) OF YOUR PROBLEM/PAIN:



5 *PERSONAL HEALTH HISTORY*

HEIGHT: ___ WEIGHT: ___ HAVE HAD ALL CHILDHOOD VACCINATIONS? ❑ Yes ❑ No ❑ Unknown

RATE YOUR OVERALL HEALTH: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

LIST ANY INCIDENTS THAT REQUIRED MEDICAL ATTENTION (Hospitalizations, Accidents, Injuries, Illnesses, Falls):

LIST ANY PRIOR SURGERIES:

ARE YOU PREGNANT? ❑ Yes ❑ No **Due Date:** ______________________

ANY ALLEGERIES: ❑ Yes ❑ No **Type:** ______________________

ANY VITAMINS: ❑ Yes ❑ No **Type:** ______________________

MEDICATIONS: ______________ **Dosage:** ______ **Reason Taken:** ______________

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HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

MRI	Date: ________	Results: ____________	Prescribing Doctor: ____________
EKG	Date: ________	Results: ____________	Prescribing Doctor: ____________
EMG	Date: ________	Results: ____________	Prescribing Doctor: ____________
X-RAYS	Date: ________	Results: ____________	Prescribing Doctor: ____________
CT SCAN	Date: ________	Results: ____________	Prescribing Doctor: ____________

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Past	Present		Past	Present		Past	Present		Past	Present	
❑	❑	Allergies	❑	❑	Elbow Pain	❑	❑	Low Back Pain	❑	❑	Scoliosis
❑	❑	Ankle Pain	❑	❑	Fibromyalgia	❑	❑	Mid Back Pain	❑	❑	Shoulder Pain
❑	❑	Arm Pain	❑	❑	Headaches	❑	❑	Migraines	❑	❑	Skin Disorder
❑	❑	Arthritis	❑	❑	Heart Disease	❑	❑	MRSA	❑	❑	Stroke
❑	❑	Asthma	❑	❑	High Blood Pressure	❑	❑	Neck Pain	❑	❑	Thyroid
❑	❑	Cancer	❑	❑	Hip Pain	❑	❑	Osteoporosis	❑	❑	TMJ
❑	❑	Diabetes	❑	❑	Knee Pain	❑	❑	Pacemaker	❑	❑	Tuberculosis
❑	❑	Dizziness	❑	❑	Leg Pain	❑	❑	Sciatica	❑	❑	Other:

6 SOCIAL HISTORY

HOW MUCH HAS THIS PROBLEM/PAIN INTERFERRED WITH:

DAILY ACTIVITIES	❑ Not at all	❑ Mild	❑ Moderate	❑ Severe
WORK ACTIVITIES	❑ Not at all	❑ Mild	❑ Moderate	❑ Severe
SOCIAL ACTIVITES	❑ Not at all	❑ Mild	❑ Moderate	❑ Severe
RECREATIONAL ACTIVITIES	❑ Not at all	❑ Mild	❑ Moderate	❑ Severe

DO YOU DO ANY OF THE FOLLOWING:

USE TOBACCO	❑ Yes	❑ No	❑ Quit	________________ Packs/Day	____ Years
USE ALCOHOL	❑ Yes	❑ No	❑ Quit	________________ How much	____ Years
USE CAFFEINE	❑ Yes	❑ No	❑ Quit	________________ How much	____ Years
USE SOCIAL DRUGS	❑ Yes	❑ No	❑ Quit	________________ How much	____ Years
DRINK SOFT DRINKS	❑ Yes	❑ No	❑ Quit	________________ How much	____ Years
EXERCISE	❑ Yes	❑ No	❑ Quit	________________ What type	____ Years
FOLLOW A SPECIAL DIET	❑ Yes	❑ No	❑ Quit	________________ What type	____ Years

7 FAMILY HISTORY

MOTHER:	❑ Living	❑ Deceased	___ Age	________________________ Any Serious Illnesses
FATHER:	❑ Living	❑ Deceased	___ Age	________________________ Any Serious Illnesses
SISTER(S):	❑ Living	❑ Deceased	___ Age	________________________ Any Serious Illnesses
BROTHER(S):	❑ Living	❑ Deceased	___ Age	________________________ Any Serious Illnesses

8 GOVERNMENT QUESTIONNAIRE

MARITAL STATUS: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partnered

EDUCATION: ❑ GED ❑ High School ❑ Associates ❑ Bachelors ❑ Masters ❑ Doctorate

ETHNICITY: ❑ Non Hispanic/Latino ❑ Hispanic/Latino

RACE: ❑ Caucasian ❑ African-American ❑ Asian-American
❑ American Indian ❑ Native Alaskan ❑ Native Hawaiian
❑ Two or more Races

LANGUAGE: ❑ English ❑ Spanish ❑ French ❑ German ❑ Vietnamese
(Spoken at home) ❑ Italian ❑ Greek ❑ Tagolog ❑ Mandarin ❑ Cantonese