

Patient Health Questionnaire

Legal Name: _____ Sex: M / F DOB: _____ Date: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Occupation: _____ Emergency Contact: _____ Ph: _____

AHC: _____ Marital Status: _____ Spouse: _____ Kids: (M) _____ (F) _____

1. Please describe your complaints: _____

a. Description

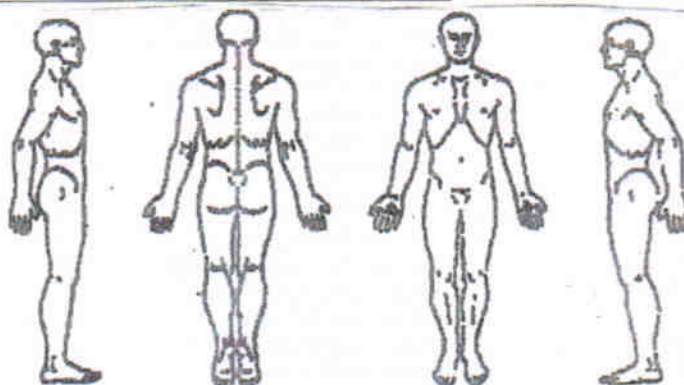
- Sharp Pain
- Dull Pain
- Ache
- Weak
- Throbbing
- Numb
- Shooting
- Gripping
- Burning
- Tingling

b. Frequency

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)



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 Increase during the day Same all day

f. Your symptoms: are localized in one area travel down the arms or legs

2. When did your problems begin? SPECIFIC DATE IF POSSIBLE: _____

Describe how your problem began: _____

3. Have you been treated for this episode? Yes No Date of treatment: _____

If yes, by whom: Chiropractor MD Massage Therapist Physical Therapist Osteopath Other _____
What did treatment consist of? _____

4. In the past have you been treated for the same or similar problem? Yes No Date of treatment: _____

If yes, by whom: Chiropractor MD Massage Therapist Physical Therapist Osteopath Other _____
What did treatment consist of: _____

5. Have you ever had an injury to the area of complaint described above? Yes No Explain: _____

6. What makes your problem better: Nothing Walking Standing Sitting Movement/Exercise Inactivity Other _____

7. What makes your problem worse: Nothing Walking Standing Sitting Movement/Exercise Inactivity Other _____

8. What self-treatment have you tried? Ice Heat Pain Medication Muscle Relaxants Other _____

9. General Physical Activity: No exercise program Light exercise program Moderate exercise program Strenuous exercise program

10. Have you ever been involved in a motor vehicle accident? Yes No Date(s): _____

11. How would you rate your stress level? Little or no stress Minimal stress Moderate stress Greatly stressed

12. Is this visit related to an MVA? Yes No Date of Injury: _____

13. If this is a WCB Claim: Date of Injury: _____ SIN: _____ Company Name/Address: _____

14. Do you have an EHC Plan?: Yes No Does it cover if AHC does not cover your visit? Yes No

Patient/Guardian's Signature: _____

Date: _____