SIGOURNEY CHIROPRACTIC AND WELLNESS

DR. KODEY SALOW
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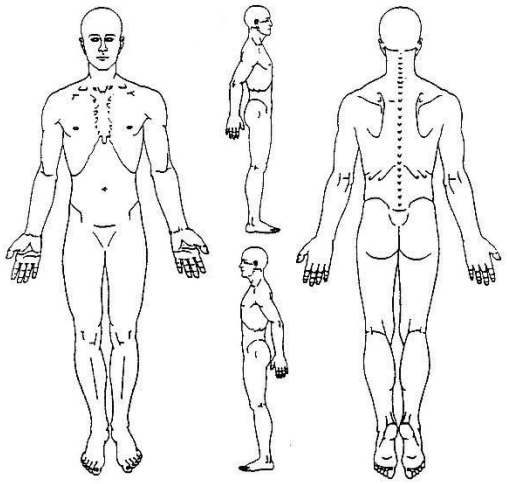
Patient Health Questionnaire

Name:_____ **Date:**_____

When and How did your symptoms start? _____

_____

How much of the day do you experience your symptoms?
Mark where you feel your symptoms:



0%-25% / 26%-50% / 51%-75% / 76%-100%

Describe your symptoms:

Sharp / Dull / Ache / Numb / Shooting / Burning / Tingling

Are your symptoms…

Getting better / Not Changing/ Getting Worse

Rate your symptoms

Best/Lowest (1-10)_____

Worst/Highest (1-10)_____

How do your symptoms affect your daily activity? (1-10)

_____

What decreases your symptoms? _____

What increases your symptoms? _____

Who have you seen for your symptoms? Medical Doctor / Physical Therapist / Chiropractor / Other

Other Previous Treatment or Tests: X-Ray / CT Scan / MRI / Other

Have you experienced this before? Yes / No **What helped before?** _____

What is your Job/Profession? _____

What are your Goals for Care? _____

_____

Medications you are taking: _____

_____

Allergies:_____

Surgeries/Major Medical Procedures/Hospitalizations (with dates):_____

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Family History of (circle all that apply): Rheumatoid Arthritis/Heart Problems/Diabetes/Cancer/ Lupus

Office Use Only:

Height: _____ Weight: _____ BP:_____ Pulse:_____

Have you experienced any of the following in the Past or Present (Circle all that apply):

Headaches
Neck Pain
Upper Back Pain
Mid Back Pain
Low Back Pain
Shoulder Pain
Elbow/Upper Arm Pain
Wrist Pain
Hand Pain
Hip/Upper Leg Pain
Knee/Lower Leg Pain
Ankle/Foot Pain
Jaw Pain
Joint Swelling/Stiffness
Arthritis
Rheumatoid Arthritis
General Fatigue
Muscular Incoordination
Visual Disturbances
Dizziness
Cancer
Tumor
High Blood Pressure
Heart Attack
Chest Pains
Stroke
Angina
Kidney Stones
Kidney Disorders
Bladder Infection
Painful Urination
Loss of Bladder Control
Prostate Problems
Abnormal Weight Gain/Loss
Loss of Appetite
Abdominal Pain
Ulcer
Hepatitis
Liver/Gall Bladder Disorder
Asthma
Chronic Sinusitis
Diabetes
Excessive Thirst
Frequent Urination
Drug/Alcohol Dependence
Depression
Systemic Lupus
Epilepsy
Dermatitis/Eczema/Rash
HIV/AIDS

Females Only
Birth Control Pills
Hormonal Replacement
Pregnancy

Please describe any details for items marked above:_____

_____

_____

Doctor Notes: _____

_____

Patient Signature:_____ Date:_____

Doctor Signature:_____Date:_____