Patient Health Questionnaire:

Date:_____

In order that the Doctor may get a complete picture of your health, please answer the following questions. All information will be treated as confidential. (Please Print)

Last Name _____First_____ Spouse's Name _____

Address _____ City _____ Postal Code _____

Home Phone_____ Work _____ Cell _____

Email _____

Date of Birth _____ Age _____ Height _____ Weight _____

Sask. Hosp. # _____ Sex ____ Marital Status _____ Number of children _____

Who referred you to this clinic? _____

Employer_____Occupation_____

Is this a Workman's Compensation Claim? Yes _____ No _____ Date of accident _____

Is this a motor vehicle accident (SGI) Claim? Yes_____ No____ Date of accident_____

Have you ever consulted a chiropractor? Yes ___ No ___ If yes, who _____

Family Physician _____ Address _____

What is your chief complaint? _____

_____

When did you first notice the symptoms? _____

Are there any secondary problems? _____

_____

Do you sleep well? Yes _____ No _____ in what position do you sleep ? _____

Do you participate in a regular exercise program? Yes _____ No _____

Have you had x-rays taken of your spine? Yes _____ No _____ If yes, when _____

Have you ever broken any bones? Yes _____ No _____ If yes, which one(s) _____

Have you been in any accident(s) in the last 2 years? _____

If you are employed, please describe what activities you do on a daily basis (for example, lifting, typing, prolonged standing or sitting).

_____

Personal Habits:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs (non-prescription)	☐	☐	☐	☐

Do you have any diagnosed medical conditions, (for example: diabetes, high blood pressure, arthritis, cancer, HIV _____

Please Circle any conditions which are PRESENTLY causing you a problem.

Please CHECK (✓) any conditions which have been a problem in the PAST.

General Symptoms:

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Loss of Weight
  Numbness or pain in arms, hands, legs
- ☐ Allergy
- ☐ Wheezing
- ☐ Nerve Pain

E.E.N.T. :

- ☐ Failing Vision
- ☐ Glasses need to see
  -distances
  -read
- ☐ Crossed Eyes
- ☐ Eye Pain
- ☐ Deafness
- ☐ Earache
- ☐ Asthma
- ☐ Tooth Decay
- ☐ Gum Trouble
- ☐ Frequent Colds
- ☐ Sinus Infection
- ☐ Runny Nose
- ☐ Enlarged Glands
- ☐ Enlarged Thyroid
- ☐ Cold Sores
- ☐ Loss of Hearing

Respiratory:

- ☐ Chronic Cough
- ☐ Spitting up Phlegm
- ☐ Spitting up Blood
- ☐ Chest Pain
- ☐ Difficult Breathing

Cardiovascular:

- ☐ Rapid Beating Heart
- ☐ High Blood Pressure
- ☐ Pain over Heart
- ☐ Stroke
- ☐ Hardening of Arteries
- ☐ Varicose Veins
- ☐ Swelling of the Ankles
- ☐ Poor Circulation
- ☐ Angina

Muscles & Joints:

- ☐ Stiff Neck
- ☐ Backache
- ☐ Swollen Joints
- ☐ Painful Tail Bone
- ☐ Foot Trouble
- ☐ Shoulder Pain
- ☐ Elbow and Wrist
- ☐ Wrist Pain
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Arthritis

Skin:

- ☐ Rashes
- ☐ Itching
- ☐ Bruises Easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives (Allergy)
- ☐ Hair Loss

Genitourinary:

- ☐ Trouble Urinating
- ☐ Blood in Urine
- ☐ Pus in Urine
- ☐ Kidney Infection
- ☐ Bed Wetting
- ☐ Prostate Trouble

G. U. for Women:

- ☐ Painful Menstruation
- ☐ Excessive Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Cramps or Backache
- ☐ Vaginal Discharge
- ☐ Swollen Breasts
- ☐ Lumps in Breasts

Gastrointestinal:

- ☐ Poor Appetite
- ☐ Indigestion
- ☐ Excessive Hunger
- ☐ Belching or Gas
- ☐ Nausea
- ☐ Vomiting (Blood?)
- ☐ Pain over Stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall Bladder trouble
- ☐ Intestinal Worms
- ☐ Ulcer

Is there anything else you feel the Doctor should know about you or your condition?

_____
_____
_____