Miller Chiropractic, LLC

PATIENT HEALTH QUESTIONNAIRE

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Last Name, First Name____**Date** ______________________

The symptoms that have prompted me to seek care today include: ____

____

They are the result of: ◯ **An accident or injury**

◯ **Work** ◯ **Auto** ◯ **Other** ____

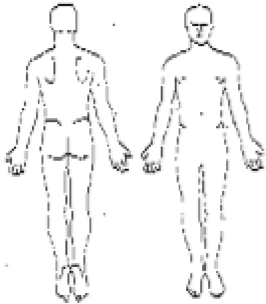
◯ **A worsening long-term problem**

◯ **An interest in:** ◯ **Wellness** ◯ **other** ____

What are your symptoms, how long has it been flared up, and how did it happen? ______________________________________

____

1) LOCATION (Where does it hurt?)
Circle the area(s) on the illustration



2) QUALITY OF SYMPTOMS
(What does it feel like?)
- ◯ Numbness
- ◯ Tingling
- ◯ Stiff/Tight
- ◯ Dull
- ◯ Aching/Sore
- ◯ Nagging
- ◯ Sharp
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other

3) INTENSITY (How extreme are your current symptoms?)
best **0 1 2 3 4 5 6 7 8 9 10** worst

4) PAIN/DISCOMFORT LEVEL: ◯ Mild ◯ Moderate ◯ Severe

5) DURATION AND TIMING: (How often do you feel it?)
◯ Occasional ◯ Intermittent ◯ Frequent ◯ Constant

6) RADIATION (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
____

7) AGGRAVATING/RELIEVING FACTORS:
What makes it worse? ____
What makes it better? ____

8) PRIOR INTERVENTIONS
(What have you done to relieve the symptoms?)
◯ Medical Doctor/ER ◯ Surgery ◯ Ice ◯ Homeopathic remedies ◯ Chiropractic ◯ Over the Counter Meds
◯ Prescription Meds ◯ Acupuncture ◯ Heat ◯ Physical Therapy ◯ Massage ◯ Other

9) REVIEW OF SYSTEMS
(Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the circle beside any condition that you've **Had** or currently **Have** and initial to the right.)

a.Musculoskeletal System

Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O
O O Osteoporosis | O O Arthritis | O O Scoliosis | O O Neck Pain | O O Back Problems | O O Hip Disorders
O O Knee Injuries | O O Foot/Ankle Pain | O O Shoulder Problems | O O Elbow/wrist pain | O O TMJ issues | O O Poor Posture | Initials ____

b.Neurological System

Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O
O O Anxiety | O O Depression | O O Headache | O O Dizziness/ Balance | O O Pins and needles | O O Numbness | Initials ____

c.Cardiovascular System

Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O
O O High Blood Pressure | O O Low Blood Pressure | O O High Cholesterol | O O Poor Circulation | O O Angina | O O Excessive Bruising | Initials ____

d.Respiratory System

Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O
O O Asthma | O O Apnea | O O Emphysema | O O Hay Fever | O O Shortness of Breath | O O Pneumonia | Initials ____

e. Digestive System

Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O
O O Anorexia/ Bulimia | O O Ulcer | O O Food sensitivities | O O Heartburn | O O Constipation | O O Diarrhea | Initials ____

f. Sensory System

Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O
O O Blurred Vision | O O Ringing in Ears | O O Hearing Loss | O O Chronic ear Infections | O O Loss of smell | O O Loss of taste | Initials ____

Name___________________________________

g. Skin System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
O O Skin Cancer	O O Psoriasis	O O Eczema	O O Acne	O O Hair loss	O O Rash	None O Initials ____

h. Endocrine System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
O O Thyroid issues	O O Immune disorders	O O Hypoglycemia	O O Frequent infection	O O Swollen glands	O O Low energy	None O Initials ____

I. Genitourinary System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
O O Kidney stones	O O Infertility	O O Bedwetting	O O Prostate issues	O O Erectile dysfunction	O O PMS symptoms	None O Initials ____

j. Constitutional System

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
O O Fainting	O O Low Libido	O O Poor appetite	O O Fatigue	O O Sudden weight gain/loss	O O Weakness	None O Initials ____

PAST PERSONAL, FAMILY AND SOCIAL HISTORY (Please identify your past health history, including accidents, injuries, illnesses and treatments.) Please complete each section fully.

10) ILLNESSES (Identify the illnesses you have **HAD** in the past or **HAVE** now.)

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
O O AIDS	O O Alcoholism	O O Cancer	O O Arteriosclerosis	O O Goiter	O O Chicken Pox
O O Diabetes	O O Epilepsy	O O Glaucoma	O O High Blood Pressure	O O Gout	O O Heart Disease
O O Hepatitis	O O HIV Positive	O O Malaria	O O Measles	O O Mumps	O O Multiple Sclerosis
O O Polio	O O Rheumatic Fever	O O Scarlet Fever	O O STDs	O O Stroke	O O Tuberculosis
O O Typhoid Fever	O O Ulcer	O O Allergies (list) ____			

11) INJURIES Have you ever… (Please indicate date or age of occurrence)

O Had a fractured or broken bone? Explain_________________________ O Had a spine or nerve disorder? Explain _______________________________

O Been knocked unconscious? ___________________________________ O Been injured in an accident? ____

O Used a crutch or other support? ________________________________ O Used neck or back bracing? ____

O Received a tattoo? ____ O Had a body piercing? ____

12) OPERATIONS (Surgical interventions, which may or may not have included hospitalization) Please include date of surgery

O Appendectomy - date ____________________ O Bypass surgery - date_________________________ O Hysterectomy - date ______________________

O Pacemaker date _________________________ O Tonsillectomy - date _________________________ O Vasectomy - date _________________________

O Cancer - date________________ type ____________________________ O Cosmetic surgery - date______________ type ____________________________

O Elective surgery - date ________________ type ____

O Spine surgery - date __________________ type ____

O Other - date ________________________explain ____

13) TREATMENTS

Past Present	Past Present	Past Present	Past Present	Past Present	Past Present
O O Acupuncture	O O Antibiotics	O O Birth Control Pills	O O Blood Transfusions	O O Chemotherapy	O O Chiropractic Care
O O Dialysis	O O Herbs	O O Homeopathy	O O Hormone Replacement	O O Inhaler	O O Massage Therapy
O O Physical Therapy					

14) MEDICATIONS (Please list ALL prescriptions and over-the-counter):

____

____

15) FAMILY HISTORY Some health issues are hereditary. Tell Dr. Miller about the health of your family members.

Relative	Illnesses	Age at death	Cause of death Natural	Cause of death Illness
Mother	______________________	__________	◯	◯
Father	______________________	__________	◯	◯
Brother/Sister	______________________	__________	◯	◯
Brother/Sister	______________________	__________	◯	◯
Maternal G-mother	______________________	__________	◯	◯
Paternal G-mother	______________________	__________	◯	◯
Maternal G-father	______________________	__________	◯	◯
Paternal G-father	______________________	__________	◯	◯

16) OCCUPATIONAL HISTORY: Occupation____

◯ Full Time ◯ Part Time ◯ Retired

17) SOCIAL HISTORY (Tell Dr. Miller about your health habits and stress levels.)

Alcohol use	◯ Daily ◯ Weekly	How much? ________________	Home pressures/stress?	◯ Yes	◯ No
Coffee use	◯ Daily ◯ Weekly	How much? ________________	Job pressures/stress?	◯ Yes	◯ No
Tobacco Use	◯ Daily ◯ Weekly	How much? ________________	Former smoker?	◯ Yes	◯ No
Exercising	◯ Daily ◯ Weekly	How much? ________________	Trying to quit	◯ Yes	◯ No
Pain Relievers	◯ Daily ◯ Weekly	How much? ________________	Need info to help quit	◯ Yes	◯ No
Soft Drinks	◯ Daily ◯ Weekly	How much? ________________	Recreational Drugs?	◯ Yes	◯ No
Water Intake	◯ Daily ◯ Weekly	How much? ________________	Hobbies: ________________________		

18) ACTIVITIES OF DAILY LIVING (How does this condition currently interfere with your life and ability to function?)

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
Sitting	O	O	O	O	Grocery shopping	O	O	O	O
Rising out of chair	O	O	O	O	Household chores	O	O	O	O
Standing	O	O	O	O	Lifting objects	O	O	O	O
Walking	O	O	O	O	Reaching overhead	O	O	O	O
Lying down	O	O	O	O	Showering or bathing	O	O	O	O
Bending over	O	O	O	O	Dressing myself	O	O	O	O
Climbing stairs	O	O	O	O	Love life	O	O	O	O
Using a computer	O	O	O	O	Getting to sleep	O	O	O	O
Getting in/out of car	O	O	O	O	Staying asleep	O	O	O	O
Driving a car	O	O	O	O	Concentrating	O	O	O	O
Looking over shoulder	O	O	O	O	Exercising	O	O	O	O
Caring for family	O	O	O	O	Yard work	O	O	O	O

19) How much sleep do you average per night? _____ Hours

May we discuss your insurance/financial information and/or appointment/treatment information with your family members?
Whom? ◯ Spouse ◯ Parent ◯ Adult Child **Which information?** ◯ All ◯ Insurance/Financial ◯ Appts. ◯ Treatment

ACKNOWLEDGEMENTS: To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement after each statement.

I instruct the chiropractor to deliver the care that, in her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. *Initials*____________

I have signed the privacy policy and been offered a copy. I understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. *Initials* _______________

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. *Initials* _______________

I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services I receive. *Initials* _______________

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. *Initials* _______________

If the patient is a minor child, print child's full name: ____

____ ______________________________

Signature Date