Robinson Chiropractic
Specializing in gentle low force care

Patient Health Questionnaire

Patient name _____ Date _____

When did your symptoms start: _____

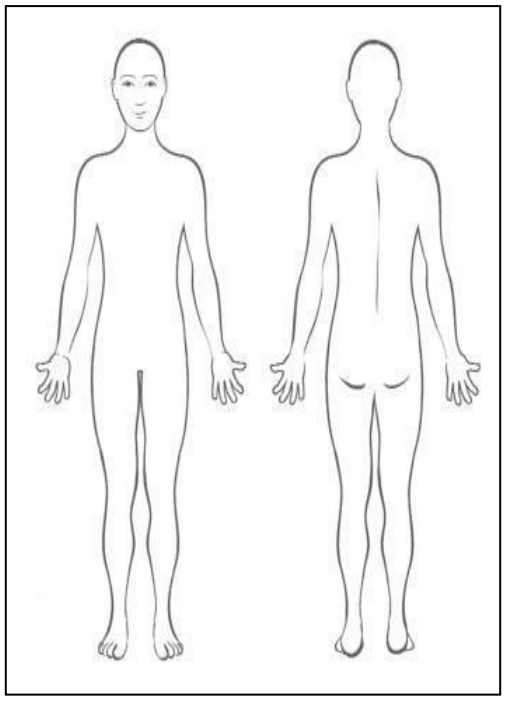
Describe your symptoms & how they began (also mark on diagram below):

_____

_____

How often do you experience your symptoms?

- Constantly (75-100% of day)
- Frequently (51-75% of day)
- Occasionally (26-50% of day)
- Intermittently (0-25% of day)



What describes the nature of your symptoms?

- Sharp
- Dull Ache
- Numb
- Shooting
- Burning
- Tingling

Rank your symptoms:

a) Today: (best) 1 2 3 4 5 6 7 8 9 10 (worst)
b) At worst: 1 2 3 4 5 6 7 8 9 10
c) At Best: 1 2 3 4 5 6 7 8 9 10

What makes symptoms worse:_____

What make symptoms better: _____

My symptoms are worse: Morning Afternoon Evening Night

Who have you seen for your symptoms? _____

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Patient name _____Date _____

What tests/imaging have you had performed?

- Xrays _____ date:_____
- MRI _____date: _____
- CT _____ date: _____
- Other _____ date:_____

Have you had similar symptoms in the past: YES NO

If yes, did you receive treatment? YES NO

Type of treatment: _____

What is your occupation: _____

What do you hope to get from your visit/treatment (select all that apply):

- Reduce symptoms
- Explanation of condition/treatment
- How to prevent this from occurring again
- Resume specific sport/activity
- Preventative care

What type of regular exercise do you perform? _____

Height _____ Weight_____

Please check all that apply:

Past	present	
		Headaches
		Neck pain
		Upper back pain
		Mid back pain
		Low back pain
		Extremity pain

Past	Present	
		Jaw pain
		Arthritis
		General fatigue
		Dizziness
		High BP
		Heart attack
		Kidney
		Hepatitis

Past	Present	
		Cancer
		Tumor
		Asthma
		Diabetes
		Smoking
		Alcohol use
		Epilepsy
		Depression

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Please list any health conditions not listed on previous page:

Past Present

_____

_____

_____

Pacemaker: YES NO

Joint replacements or implants:

YES NO

Explain: _____

_____

Pregnant: YES NO

If yes, _____weeks

COMPLICATIONS: YES NO

Explain:_____

_____

SURGERIES:

_____

_____

_____

_____

HOSPITALIZATIONS:

_____

_____

_____

_____

MEDICATIONS/SUPPLEMENTS:

_____

_____

_____

_____

_____

FAMILY HEALTH HISTORY:

please check all that apply

__CANCER __ RHEUMATOID ARTHRITIS __ DIABETES __ LUPUS __HEART CONDITIONS

__HIGH BLOOD PRESSURE __ OSTEOARTHRITIS __OTHER: _____

By signing below, I consent for this information to be used in evaluation and treatment at Robinson Chiropractic. I have provided my most accurate health related information.

Patient signature_____ Date_____

Doctor's notes: