

PATIENT HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Email: \_\_\_\_\_
(NOTE: all appointment reminders are sent by email unless requested otherwise)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Gender: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Are you pregnant? Yes / No
If yes, due date: \_\_\_\_\_

Marital Status:
Single Partnered, yrs Married, yrs Separated, yrs Divorced, yrs Widow(er), yrs

Are you recovering from a cold or flu? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Company/School: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation/Course of Study: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best time to reach you: \_\_\_\_\_

Emergency Contact:
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason(s) for your office visit today: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_
Practitioner name and phone number: \_\_\_\_\_
Lab tests performed (e.g. stool, blood, urine, saliva, hair): \_\_\_\_\_
Outcome: \_\_\_\_\_

\*If pertinent to your visit today, please bring photocopies of your most recent lab test results to your first appointment.

What types of therapy have you tried for this problem(s)?
diet modification vitamins/minerals herbs homeopathy chiropractic acupuncture
conventional drugs other: \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Current medications (prescription and over-the-counter): \_\_\_\_\_  
\_\_\_\_\_

Known allergies or sensitivities (e.g. medications, bee stings, foods): \_\_\_\_\_  
\_\_\_\_\_

Major hospitalizations, surgeries and injuries:  
(Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness or Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g. changes in job, work, residence or finances, legal problems): \_\_\_\_\_  
\_\_\_\_\_

Do you consider yourself: \_\_\_ underweight \_\_\_ overweight \_\_\_ just right Your weight today: \_\_\_\_\_

Have you experienced an unintentional weight loss or gain of 10 pounds in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life-threatening activities such as a fireman, farmer or miner? \_\_\_\_\_  
\_\_\_\_\_

Do you wear: \_\_\_ corrective lenses \_\_\_ dentures \_\_\_ hearing aid \_\_\_ medical devices/prosthetics/implants  
Describe: \_\_\_\_\_

Any recent changes in your ability to: \_\_\_ see \_\_\_ hear \_\_\_ taste \_\_\_ smell \_\_\_ feel hot/cold sensations  
\_\_\_ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Do you have a strong preference for any of the following flavors: \_\_\_ sour \_\_\_ bitter \_\_\_ sweet \_\_\_ rich/fatty  
\_\_\_ spicy/pungent \_\_\_ salty

Do you have a strong dislike of any of the following flavors: \_\_\_ sour \_\_\_ bitter \_\_\_ sweet \_\_\_ rich/fatty  
\_\_\_ spicy/pungent \_\_\_ salty

Do you: \_\_\_ prefer warmth (i.e. food, drinks, weather, etc.) \_\_\_ prefer cold (i.e. food, drinks, weather, etc.)  
\_\_\_ no preference

Is your sleep disturbed at the same time every night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the most energy or the least symptoms:	Time of day you feel the worst or your symptoms are aggravated:
___ 7-9a.m.      ___ 9-11a.m.      ___ 11a.m.-1p.m.	___ 7-9a.m.      ___ 9-11a.m.      ___ 11a.m.-1p.m.
___ 1-3p.m.      ___ 3-5p.m.      ___ 5-7p.m.	___ 1-3p.m.      ___ 3-5p.m.      ___ 5-7p.m.
___ 7-9p.m.      ___ 9-11p.m.      ___ 11p.m.-1a.m.	___ 7-9p.m.      ___ 9-11p.m.      ___ 11p.m.-1a.m.
___ 1-3a.m.      ___ 3-5a.m.      ___ 5-7a.m.	___ 1-3a.m.      ___ 3-5a.m.      ___ 5-7a.m.

Do you experience any of these general symptoms EVERY DAY?

___ debilitating fatigue	___ shortness of breath	___ insomnia	___ constipation	___ chronic pain/inflammation
___ depression	___ panic attacks	___ nausea	___ bleeding	___ fecal incontinence
___ disinterest in sex	___ headaches	___ vomiting	___ discharge	___ urinary incontinence
___ disinterest in eating	___ dizziness	___ diarrhea	___ itching/rash	___ low grade fever