

# PATIENT HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Date: M \_\_\_/D \_\_\_/Y \_\_\_

**PRESENT COMPLAINTS. PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.**

In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

1. Present complaint \_\_\_\_\_

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS):

- Sharp Stabbing  
  Sharp/Dull  
  Aches  
  Dull  
  Soreness  
  Weakness  
  Throbbing/Gnawing  
  Numbness  
  Shooting  
 Gripping/Constricting  
 Burning  
 Tingling

3. How often are the complaints present?  Constant (76-100%)  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

4. How bad is your pain or ache? Please circle a number? 0 1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable Pain

5. Since your problem began is the pain:  Increasing  Decreasing  Not Changing

6. When did your problem begin: SPECIFIC DATE IF POSSIBLE: \_\_\_\_\_

7. Did your problem begin:  Immediately after a specific incident  Multiple incidents  Gradually develop over time  No specific reason

8. Describe how your problem began \_\_\_\_\_

9. What treatment have you received for this present condition?  Surgery  Spinal injections  Therapy from a PT  A back support

10. Were you previously treated for a different occurrence of this same condition?  yes  no If yes by:  Chiropractor  MD  Therapist  
 Other: \_\_\_\_\_ (SPECIFY DATES & TYPE OF TREATMENT WITH RESULTS): \_\_\_\_\_

11. What makes your problem better?  Nothing  Lying Down  Walking  Standing  Sitting  Movement Exercise  Inactivity  
 Other \_\_\_\_\_

12. What makes your problem worse?  Nothing  Lying Down  Walking  Standing  Sitting  Movement Exercise  Inactivity  
 Other \_\_\_\_\_

13. How would you grade your general stress level?  No Stress  Minimal Stress  Moderate Stress  Greatly Stressed

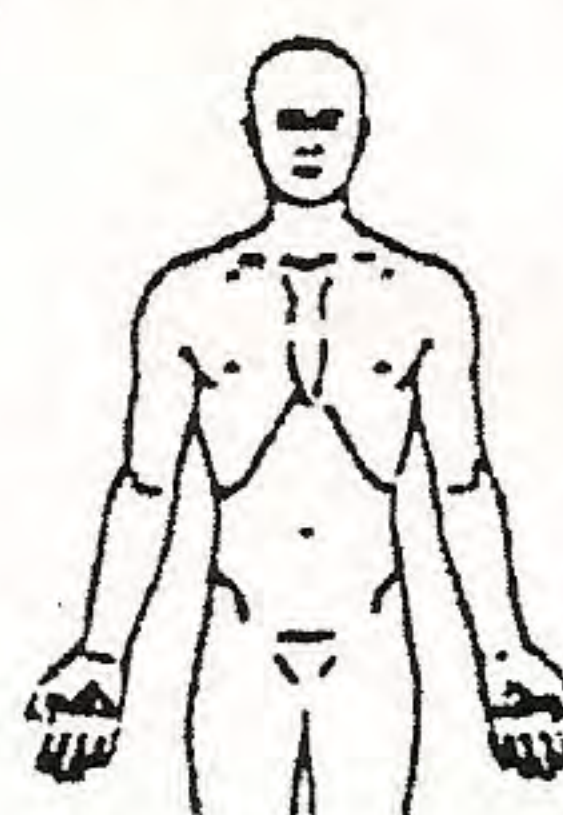
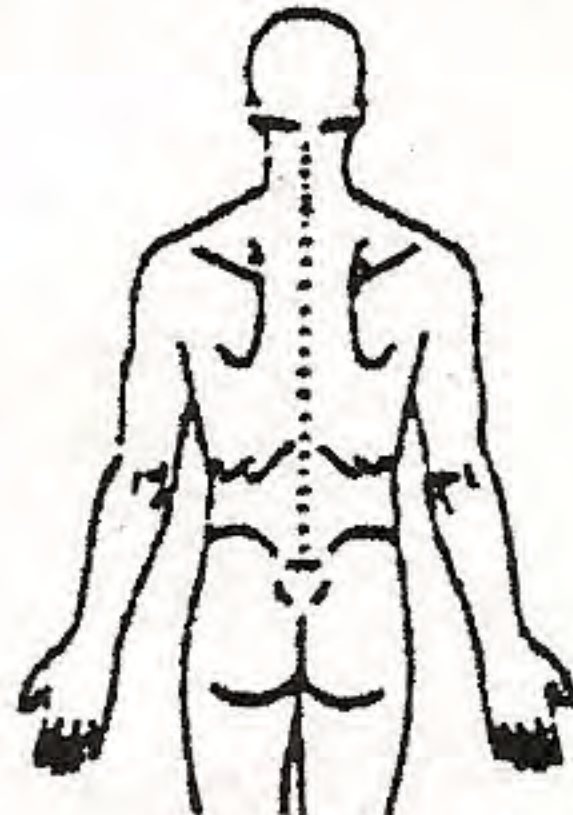
14. Physical activity at work?  Sitting More Than 50% of the workday  Light Manual Labor  Manual Labor  Heavy Manual Labor

15. General physical activity:  No Regular Exercise Program  Light Exercise Program  Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?

- |  |  |
|--|--|
| <input type="checkbox"/> No effect.  | <input type="checkbox"/> Some physical restrictions (able to perform light duty work and household tasks). |
| <input type="checkbox"/> Need limited assistance with common everyday tasks          | <input type="checkbox"/> Need assistance often.  |
| <input type="checkbox"/> Have a significant inability to function without assistance | <input type="checkbox"/> Am totally disabled (impaired). Cannot care for self                              |

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDING SYMPTOMS OF PAIN, NUMBNESS OR TINGLING.



Your Name: \_\_\_\_\_

**HEAD:**

- \_\_\_\_ 1. Headache
- \_\_\_\_ 2. sinus (allergy)
- \_\_\_\_ 3. entire head
- \_\_\_\_ 4. back of head
- \_\_\_\_ 5. forehead
- \_\_\_\_ 6. temples
- \_\_\_\_ 7. migraine
- \_\_\_\_ 8. frequent and severe
- \_\_\_\_ 9. Head feels heavy
- \_\_\_\_ 10. Lightheadedness
- \_\_\_\_ 11. Fainting
- \_\_\_\_ 12. Face flushed
- \_\_\_\_ 13. Loss of memory
- \_\_\_\_ 14. Eye strain
- \_\_\_\_ 15. Light bothers eyes
- \_\_\_\_ 16. Blurred vision
- \_\_\_\_ 17. Double vision
- \_\_\_\_ 18. Loss of vision
- \_\_\_\_ 19. Loss of balance
- \_\_\_\_ 20. Dizziness
- \_\_\_\_ 21. Loss of hearing
- \_\_\_\_ 22. Pain in the ears
- \_\_\_\_ 23. Ringing in the ears R L
- \_\_\_\_ 24. Buzzing in the ears R L
- \_\_\_\_ 25. Loss of taste
- \_\_\_\_ 26. Loss of smell
- \_\_\_\_ 27. Sinus trouble

**NECK:**

- \_\_\_\_ 30. Neck pain
- \_\_\_\_ 31. Neck stiffness
- \_\_\_\_ 32. Neck pain and stiffness
- \_\_\_\_ 33. Moderate to severe neck pain
- \_\_\_\_ 34. Neck pain with movement
- \_\_\_\_ 35. forward
- \_\_\_\_ 36. backward
- \_\_\_\_ 37. turning to the left
- \_\_\_\_ 38. turning to the right
- \_\_\_\_ 39. bending to the left
- \_\_\_\_ 40. bending to the right
- \_\_\_\_ 41. Pinched nerve in the neck
- \_\_\_\_ 42. Neck feels "out of place"
- \_\_\_\_ 43. Muscle spasms in the neck
- \_\_\_\_ 44. Grinding sounds in the neck
- \_\_\_\_ 45. Arthritis in the neck

**SHOULDERS:**

- \_\_\_\_ 50. Pain in shoulder joint R L
- \_\_\_\_ 51. Pain across shoulders
- \_\_\_\_ 52. Pain between shoulder blades
- \_\_\_\_ 53. Stiffness in shoulder R L
- \_\_\_\_ 54. Tension in the shoulders
- \_\_\_\_ 55. Pinched nerve - shoulder R L
- \_\_\_\_ 56. Muscle spasms - shoulder R L
- \_\_\_\_ 57. Unable to raise arm R L
- \_\_\_\_ 58. above shoulder level R L
- \_\_\_\_ 59. over head R L

**ARMS & HANDS:**

- \_\_\_\_ 65. Pain in the upper arm R L
- \_\_\_\_ 66. Pain in the elbow R L
- \_\_\_\_ 67. Tennis elbow R L
- \_\_\_\_ 68. Pain in forearm R L
- \_\_\_\_ 69. Pain in hands R L
- \_\_\_\_ 70. Pain in fingers of R L hand
- \_\_\_\_ 71. Sensation of pins & needles in the arm R L
- \_\_\_\_ 72. Sensation of pins & needles in the fingers R L
- \_\_\_\_ 73. Numbness in arms R L
- \_\_\_\_ 74. Numbness in fingers R L
- \_\_\_\_ 75. Fingers go to sleep R L
- \_\_\_\_ 76. Hands get cold
- \_\_\_\_ 77. Swollen joints in fingers
- \_\_\_\_ 78. Stiffness in fingers R L
- \_\_\_\_ 79. Loss of grip strength R L

**MID-BACK:**

- \_\_\_\_ 82. Mid-back pain
- \_\_\_\_ 83. Mid-back stiffness
- \_\_\_\_ 84. Mid-back pain and stiffness
- \_\_\_\_ 85. Mid-back muscle spasms
- \_\_\_\_ 86. Pain in kidney area

**CHEST:**

- \_\_\_\_ 90. Chest pain
- \_\_\_\_ 91. Shortness of breath
- \_\_\_\_ 92. Pain around the ribs
- \_\_\_\_ 93. Breast pain
- \_\_\_\_ 94. Irregular heartbeat

**ABDOMEN:**

- \_\_\_\_ 100. Nervous stomach
- \_\_\_\_ 101. Nausea
- \_\_\_\_ 102. Gas
- \_\_\_\_ 103. Constipation
- \_\_\_\_ 104. Diarrhea
- \_\_\_\_ 105. Hemorrhoids

**LOW BACK:**

- \_\_\_\_ 110. Low back pain
- \_\_\_\_ 111. Low back stiffness
- \_\_\_\_ 112. Low back pain and stiffness
- Low back pain is worse when:
- \_\_\_\_ 114. working
- \_\_\_\_ 115. lifting
- \_\_\_\_ 116. stooping
- \_\_\_\_ 117. standing
- \_\_\_\_ 118. sitting
- \_\_\_\_ 119. bending
- \_\_\_\_ 120. coughing
- \_\_\_\_ 121. lying down (sleeping)
- \_\_\_\_ 122. walking
- \_\_\_\_ 125. Low back feels out of place
- \_\_\_\_ 126. Muscle spasms in low back

**HIPS, LEGS & FEET:**

- \_\_\_\_ 130. Pain in buttocks R L
- \_\_\_\_ 131. Pain in the hip joint R L
- \_\_\_\_ 132. Pain down the leg R L
- \_\_\_\_ 133. Pain down both legs
- \_\_\_\_ 134. Leg cramps R L
- \_\_\_\_ 135. Cramps in feet R L
- \_\_\_\_ 136. Knee pain R L
- \_\_\_\_ 137. inside R L
- \_\_\_\_ 138. outside R L
- \_\_\_\_ 139. Pins & needles in legs R L
- \_\_\_\_ 140. Numbness of leg R L
- \_\_\_\_ 141. Numbness of feet R L
- \_\_\_\_ 142. Numbness of toes R L
- \_\_\_\_ 143. Swollen ankles R L
- \_\_\_\_ 144. Swollen feet R L
- \_\_\_\_ 145. Feet feel cold

**WOMEN ONLY:**

- \_\_\_\_ 150. Menstrual pain (where) \_\_\_\_\_
- \_\_\_\_ 151. Menstrual cramping
- \_\_\_\_ 152. Irregular period
- \_\_\_\_ 153. Abnormal discharge
- \_\_\_\_ 155. Tumors

**MEN ONLY:**

- \_\_\_\_ 160. Urinary frequency
- \_\_\_\_ 161. Difficulty in starting urination
- \_\_\_\_ 162. Night urination
- \_\_\_\_ 163. Prostate pain/swelling

**GENERAL:**

- \_\_\_\_ 170. Anxiety
- \_\_\_\_ 171. Nervousness
- \_\_\_\_ 172. Irritable
- \_\_\_\_ 173. Difficulty in prolonged riding in an automobile
- \_\_\_\_ 174. Depression
- \_\_\_\_ 175. Fatigue
- \_\_\_\_ 176. Generally feel run down
- \_\_\_\_ 177. Difficulty sleeping
- \_\_\_\_ 178. Loss of weight \_\_\_\_\_ lbs.
- \_\_\_\_ 179. Gain weight \_\_\_\_\_ lbs.
- \_\_\_\_ 180. Excessive perspiration
- \_\_\_\_ 181. Pallor
- \_\_\_\_ 182. Tremors

Write in your own symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had any falls, auto accidents, or injuries? Yes _____ No _____ Please Describe	Age at time or month and year	Type of accident / briefly describe	Treatment and/or Complications

Have you had surgery or been hospitalized? Yes _____ No _____ Please Explain	Age at time or month and year	Type of surgery or reason for hospitalization	Complications, if any and/or Comments

Have you ever dislocated, fractured or broken any bones? Yes _____ No _____ Please Describe	Age at time or month and year	Area involved / which bone(s)	Associated with what injury

Have you ever suffered from a major or lengthy illness? (childhood and adult) Yes _____ No _____ Please Explain	Age at time or month and year	Illness	Complications if any and/or comments

Date of last physical exam? \_\_\_\_\_  
 Reason for exam and results: \_\_\_\_\_

Date of most recent x-rays? \_\_\_\_\_  
 Area(s) x-rayed and reasons: \_\_\_\_\_

Are you presently taking medications or drugs? Yes _____ No _____ Please List	Name of drug(s)	Doses/Day	Length of time taking and for what condition

Do you take vitamins or minerals? Yes _____ No _____ Please List	Type/Brand	Amount/Frequency

Do you wear heel lifts? Yes \_\_\_\_\_ No \_\_\_\_\_ Arch supports? Yes \_\_\_\_\_ No \_\_\_\_\_ Sole lifts? Yes \_\_\_\_\_ No \_\_\_\_\_ Inner soles? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Have you ever had a spinal tap or spinal injection? Yes \_\_\_\_\_ Date \_\_\_\_\_ No \_\_\_\_\_  
 Were you ever knocked unconscious? Yes \_\_\_\_\_ Date(s) \_\_\_\_\_ No \_\_\_\_\_  
 If female, are you, or is it possible that you may be pregnant now? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Do you suffer from any conditions other than those which you are now consulting this office for?  
 Yes \_\_\_\_\_ Please explain \_\_\_\_\_ No \_\_\_\_\_

Habits:	Heavy	Moderate	Light	None	Habits: (Cont.)	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____	Exercise	_____	_____	_____	_____
Coffee	_____	_____	_____	_____	Sleep	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	Appetite	_____	_____	_____	_____
Drugs	_____	_____	_____	_____		_____	_____	_____	_____

Patient Registration Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Children (Names & Ages) \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Employed By \_\_\_\_\_

Occupation \_\_\_\_\_

Activities at Work \_\_\_\_\_

How Did You Hear about Dr. Cayer?  Website  Yellow Pages  Newcomers Letter  
 Club/Lecture  Friend  Church/Restaurant Flyer  Other

If Friend or Other Please Comment \_\_\_\_\_

Primary Insurance

\*At initial visit we will need a copy of insurance card

Person Responsible for Account \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Person Responsible Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Additional Insurance

Is Patient covered by additional insurance?  Yes  No

If yes, subscriber name \_\_\_\_\_

Assignment & Release

I, the undersigned certify that I (or my dependent) have Insurance Coverage with \_\_\_\_\_ and assign directly to Dr. Cayer all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of my benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Dr. Cayer's Health and Wellness Center  
97 South Main Street  
Newtown, CT 06470