

## Chiropractic Clinic

# Patient Health Questionnaire

401 South Main Street, Suite 104 Blacksburg, VA 24060 540.552.5202 • www.southmainchiro.com

Date: \_\_\_\_\_

Last Name	First Name	M.I	
Address		Apt #	
City	State	Zip	
Home Phone	Mobile Phone		
Date of Birth	Age	Gender: Male Female	
Occupation	Employer		
Health Care Plan Provider (if applicable) _			_
Are you new to South Main Chiropractic?	Yes No		
How did you hear about our clinic?			_
Height Ft In. Weight	Lbs.		

#### What brings you to the clinic?

What is your primary complaint?

Is your injury related to an auto accident? (circle) Yes No

Is your injury work related? (circle) Yes No

Please describe the circumstances of your complaint:

Please describe your complaint (circle all that apply)

Sharp Pain Throbbing

Dull Pain Numbness/Tingling

Ache Shooting
Weak Burning

Please describe the frequency of your complaint (circle)

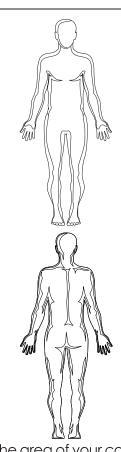
Constant (76%) Occasional (26-50%)

Frequent (51-75%) Intermittent (25% or less)

Indicate intensity of your pain at its lowest and highest level

No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Pain

#### Areas of Complaint



Please mark the area of your complaint and/or symptoms by circling or shading the example.

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Signature -

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Are your symptoms:	Decrec	asing 1	Not Changing	Getting	y Wor	se			
Symptoms are worse in	the:	Mornir	ng Afternoon	Night	Sc	ame All [	Day		
Does the problem/pain	radia	te or tra	vel to any other o	areas in	your	body?	Yes No		
If so, where?									
Do you have any numb	ness c	r tingling	g in your body?	Yes	No				
If so, where?									
What makes your problem better?  Nothing Sitting  Lying Down Movement/Exercise  Walking Inactivity  Standing		In the last 5 years have you had any of the following?  Drugs/Medications  Surgery/Hospitalization							
· ·	em wa	orse?							
What makes your problem worse?  Nothing Sitting			Previous Illnesses						
Lying Down Movement Walking Inactivity Standing		nent/Exercise ity	Previous Traumas						
Neck Pain Jaw pain		Ur S'	Arthritis Headache/Mig			hec Present	k all that Chest Pain/Angina Asthma	apply.  Past Present	
Shoulder Pain Arm/Elbow Pain Wrist/Hand Pain Upper Back Pain Lower Back Pain Hip or Leg Pain Knee Pain Foot/Ankle Pain			Dizziness Epilepsy/Seizure Nervousness Depression Sleeping Proble Chronic Fatigue High Blood Press Heart Problems	ms ÷			Emphysema Allergies Ulcers Acid Reflux Irritable Bowel Kidney/Bladder Diabetes Cancer		
Please check the approfamily and F for you fath				of fam	nily illr	ness. Circ	le M for your mother'	s side of the	
Heart Disease High Blood Pressure Lung Problems Arthritis Patient/Guardian		F F F	Diabetes Back Problems Migraines Epilepsy/Seizures	N N S	4 F	: :	Allergies/Asthma Cancer	M F M F	