HealthTouch Chiropractic
11481 SW Hall Blvd, suite 101
Tigard, OR 97223

NAME_____ DATE _____

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:_____

_____

PATIENT HEALTH QUESTIONNAIRE - PAGE 1

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 (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (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 developed 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 ☐ Medication(s) _____ ☐ Other _____ If none check here ☐

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

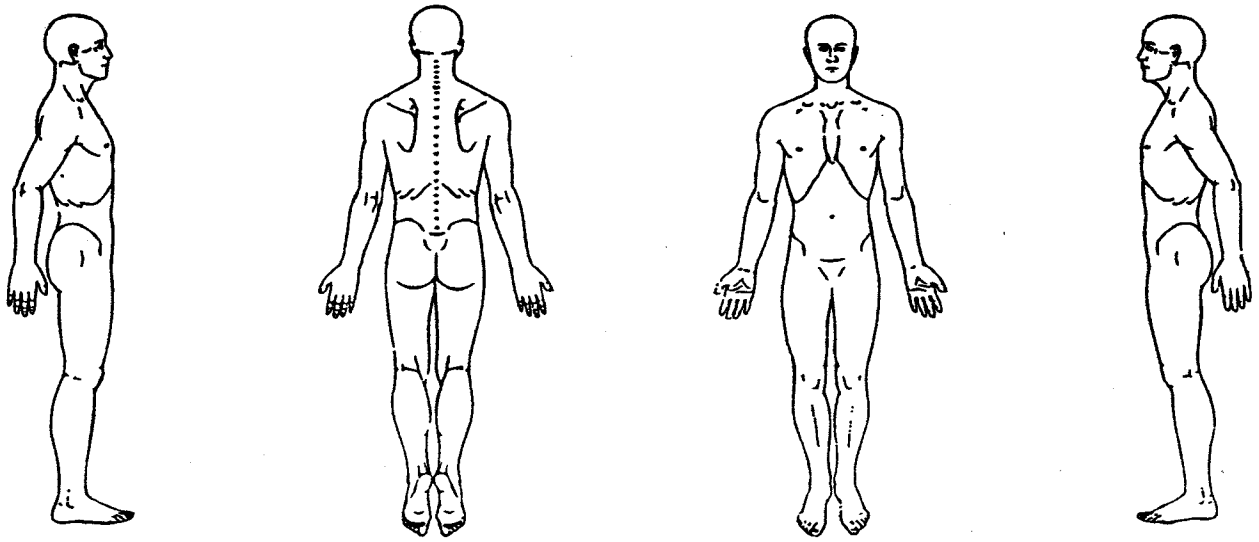
14. Physical activity at work: ☐ Sitting More Than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

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?

☐ No effect
☐ Some physical restrictions (able to perform light duty work and houshold tasks).
☐ Need limited assistance with common everyday tasks.
☐ Need assistance often.
☐ Have a significant inability to function without assistance.
☐ Am totally disabled (impaired). Cannot care for self.

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



Patient's Signature:_____ Date:_____

Health Touch Chiropractic 11481 SW Hall Blvd #101, Tigard OR 97223 503-941-9912

Name _____ Date _____

If you have ever *had* a listed symptom in the *past*, please check that symptom in the *Past column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. Most manifestation code listings are provided for the doctor's referrence.

PATIENT HEALTH QUESTIONNAIRE - PAGE 2

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting, Visual Disturbances, Nausea (780.2)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)

Present: Weight _____ pounds

Height ____ feet _____ inches

Past	Present	
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Vaginal Discharge (623.5)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)

Please check any of the following that apply to you.

☐	☐	Tobacco use (305.1)
☐	☐	Alcohol use (305.0)
☐	☐	Birth Control Pills used
☐	☐	Medications (please list them) _____
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Pregnancy
☐	☐	Surgical Procedures (please list them) _____
☐	☐	Coffee/Tea/Caffeinated Soft drinks, cups per day_____

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location _____
☐	☐	Date rating received ____/____/____
		Rating Percentage _____%

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition
☐	☐	Depression (311)
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Prostate Problems (601.9)
☐	☐	Anorexia (783.0)
☐	☐	Blood Disorder (790.6)

Past	Present	Condition
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Diabetes (250.0)
☐	☐	Ulcer (556.9)
☐	☐	Kidney Stones (592.0)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Other_____

Patient's Signature:_____ Date:_____