Dr. C. Daniel Smith
Dr. William Humphreys
Dr. Brett Miller
Dr. Corey Trease
Dr. Brian Duncan

Dr. ______________________

Today's Date: ______________________

PATIENT HEALTH QUESTIONNAIRE

Name: ______________________ D.O.B.: __________ Age: _____ Male: ____ Female: ____

Have you ever been seen in the office before? Yes No

Is this injury or problem work related? Yes No

Referred by (Check One):

____ Self ____ Family ____ Friend ____ Doctor ____ Other Health Professional ____ Attorney

Name of Person Making Referral: ______________________

Name of Primary Care Physician: ______________________

What is the nature of your injury or problem? ______________________

Date of Injury or Onset of Current Problem: ______________________

Please describe the reason for your visit today:

____

____

____

Your Pain Level Now (Circle One): 0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Severe Pain

Describe Your Pain (Check All That Apply):

Sharp	______	Constant	______	Wakes Me up at Night	______
Stabbing	______	Worse With Activity	______	Getting Better	______
Dull	______	Only With Activity	______	Getting Worse	______
		Relieved With Rest	______	Staying the Same	______

Please describe any previous treatment for this problem (please include physical therapy, surgery, injections, medications, etc.):

____

____

NURSING ONLY: PLEASE DO NOT WRITE IN THIS BOX

Ht: ______ Wt: ______ Pulse: ______ Resp Rate: ______ RHD: ______ LHD: ______

ASSESSMENT: ______________________

____

____

____

KNEE:

Popping: ______ Swelling: ______ Locking: ______ Give Way: ______ Limp: ______

Continued on Back of Page

Patient Name: ____________________

PAST MEDICAL HISTORY & SYSTEMS REVIEW (Check All That Apply):

Headaches ____ Cancer ____ Convulsions ____ Blurred Vision ____
Kidney Disease ____ Seizures ____ Hearing Loss ____ Yellow Jaundice ____
Anxiety ____ Fainting Episodes ____ Venereal Disease ____ Depression ____
Chest Pain ____ Tuberculosis ____ Thyroid Problems ____ Angina ____
Bronchitis ____ Diabetes ____ Rheumatic Fever ____ Shortness of Breath ____
Hepatitis ____ High Blood Pressure ____ Emphysema ____ Blood Transfusion ____
Heart Attack ____ Poor Circulation ____ Blood Disorders ____ Swollen Ankles ____
HIV/AIDS ____ Pregnancy ____ Skin Problems ____ Incontinence ____
Diarrhea/Constipation ____

List Any Additional Medical Problems Below:

____________________ ____________________
____________________ ____________________
____________________ ____________________

PAST SURGICAL HISTORY:

Previous Operations: Approximate Year:

1. ____________________ ____________
2. ____________________ ____________
3. ____________________ ____________
4. ____________________ ____________
5. ____________________ ____________

Any previous fractures? ____ Yes ____ No If yes, please describe: ____________________

Any serious injuries? ____ Yes ____ No If yes, please describe: ____________________

MEDICATIONS:

Drug Allergies (Please Circle): Yes No (If yes, please list which medicines): ____________________

Please list your current medications and dosage:

Name of Drug Dose

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

SOCIAL HISTORY:

Occupation: ____________________ Job Duties: ____________________

Do you smoke? ____ Yes ____ No ____ In the Past If yes, how much? ____________________

Do you drink alcohol? ____ Yes ____ No

Do you regularly wear your seat belt? ____ Yes ____ No

FAMILY HISTORY (Any History of Parents or Siblings With Serious Medical Conditions): Yes No

If yes, please list which family member and their medical problem: ____________________

DOCTOR ONLY: PLEASE DO NOT WRITE IN THIS BOX.

I have reviewed this information with the patient:

Doctor's Signature: ____________________ Date: ____________