**Dakota Family Chiropractic**
**John W. Prunty, D.C.**
708 E Kay Ave
PO Box 1006
Mitchell, SD 57301-7006

# *Patient Health Questionnaire*

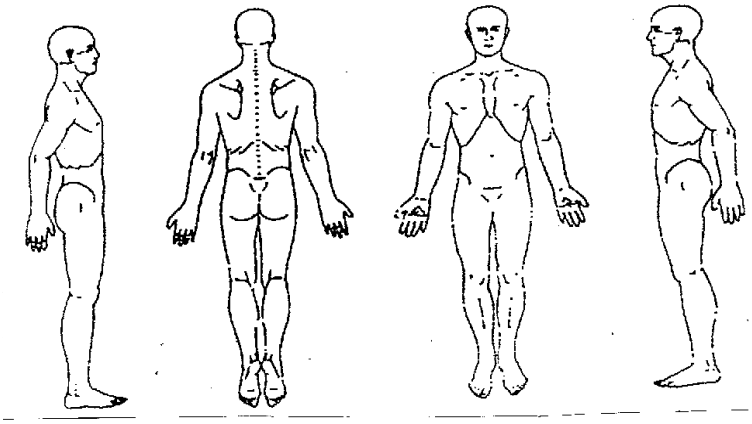
*(Please Print)*

Patient Name _____ Date _____

When did your symptoms start? _____ Describe your symptoms and how they began _____

_____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

- ☐ 1-Constantly (76-100% of day)
- ☐ 2-Frequently (51-75% of day)
- ☐ 3-Occasionally (26-50% of day)
- ☐ 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numbness ☐ Tingling

How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

What is the intensity of your symptoms as their:

| | None | | | | | | | | | Unbearable |
|---|---|---|---|---|---|---|---|---|---|---|
| Worst | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 |
| Best | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Who have you seen for this episode of your symptoms? ☐ No One ☐ Medical Doctor ☐ Other ☐ Other Chiropractor ☐ Physical Therapist

When and what treatment? _____

Have you had the same or similar symptoms in the past? ☐ Yes ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This Office ☐ Medical Doctor ☐ Other ☐ Other Chiropractor ☐ Physical Therapist

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? ☐ Yes ☐ No

Describe your restrictions _____

What type of regular exercise do you perform? ☐ 1-None ☐ 2-Light ☐ 3-Moderate ☐ 4-Strenous

Do you have a permanent disability rating? ☐ Yes ☐ No Rating % _____ Date Rating Received _____

Describe your disability _____

(Cont on back)

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past.
If you presently have a condition listed below, place a check in the Present column.

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Emphysema |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Asthma |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Chest Pains | ☐ | ☐ | Chronic Cough |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Stroke | ☐ | ☐ | Chronic Sinusitis |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Rapid Heart Beat | | | |
| | | | ☐ | ☐ | Angina | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Shoulder Pain | ☐ | ☐ | Aortic Aneurysm | ☐ | ☐ | Excessive thirst |
| ☐ | ☐ | Elbow, Upper Arm Pain | ☐ | ☐ | Blood Disorder | ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Wrist Pain | | | | | | |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Depression |
| | | | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Hip/Upper Leg Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Knee/Lower Leg Pain | ☐ | ☐ | Painful Urination | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Ankle/Foot Pain | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Dermatitis/Eczema/Rash |
| | | | ☐ | ☐ | Prostate Problems | ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | Jaw Pain | | | | | | |
| ☐ | ☐ | Joint Swelling/Stiffness | ☐ | ☐ | Abnormal Weight gain/loss | | | |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Anorexia | | | |
| ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | Loss of Appetite | | | |
| | | | ☐ | ☐ | Abdominal Pain | Females Only | | |
| ☐ | ☐ | General Fatigue | | | | ☐ | ☐ | Irregular Menstrual Flow |
| ☐ | ☐ | Muscular Incoordination | ☐ | ☐ | Difficulty Swallowing | ☐ | ☐ | Profuse Mentrual Flow |
| ☐ | ☐ | Fainting | ☐ | ☐ | Constipation | ☐ | ☐ | Breast Soreness/Lumps |
| ☐ | ☐ | Visual Disturbance | ☐ | ☐ | Heartburn Indigestion | ☐ | ☐ | Endometriosis |
| ☐ | ☐ | Convulsions | ☐ | ☐ | Ulcer | ☐ | ☐ | PMS |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Colitis | ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Tinnitus (ear noises) | ☐ | ☐ | Irritable Colon | ☐ | ☐ | Hormonal Replacement |
| | | | | | | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Cancer | ☐ | ☐ | Hepatitis | | | |
| ☐ | ☐ | Tumor | ☐ | ☐ | Liver/Gall Bladder Disorder | | | |

Indicate if an immediate family member has had any of the following

| | | | | |
|---|---|---|---|---|
| ☐ Chronic Back Problems | ☐ Rheumatoid Arthritis | ☐ High Blood Pressure | ☐ Cancer | ☐ Lupus |
| ☐ Chronic Headaches | ☐ Lung Problems | ☐ Heart Problems | ☐ Diabetes | ☐ Other |

List all the surgical procedures you have had and times you have been hospitalized

_____ _____ _____

List all accident and/or injuries: (Especially those related to your present problems)

_____ _____ _____

**Doctors Additional Comments:**

_____

_____

Doctor Signature _____ Date _____