

**SMITH CHIROPRACTIC**8821 Valley View Street Buena Park CA 90620  
(714) 527 3332**PATIENT HEALTH QUESTIONNAIRE**

DATE \_\_\_\_\_

Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

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

Cell Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Work Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ ext # \_\_\_\_\_ Email \_\_\_\_\_

Soc. Sec # \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_ Sex M / F Status M S W D # of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Address \_\_\_\_\_

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

Spouse's Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Person Responsible for this Account \_\_\_\_\_ Health Plan \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

1. **How did you hear about our office?** \_\_\_\_\_2. **Is your injury related to work**  NO  YES

If Yes, date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you the report injury to your supervisor  NO  YES3. **Is your injury relate to an auto accident**  NO  YES

If Yes, date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Was a police report filed  NO  YES4. **How do you intend on paying for today's visit** \_\_\_\_\_5. **Please list the name of the of the doctor who cares for you & your family**

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

6. **Would you like us to send a report of our findings to this physician?**  NO  YES

I authorize Stephen W. Smith, D.C. to release any X-rays taken at Smith Chiropractic to radiologist, Tracy Hoyt, D.C. for diagnostic review. I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will prepare initial billings to assist me in making collections from the insurance company and that any amount authorized will be credited to my account on receipt. I clearly understand and agree that I am responsible for payment of all services rendered to me.

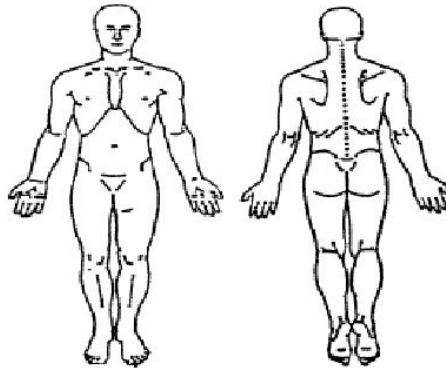
Patient / Guardian Signature \_\_\_\_\_ Today's date \_\_\_\_\_

**SMITH CHIROPRACTIC**

8821 Valley View St. Buena Park CA 90620  
(714) 527-3332

**Patient Health Questionnaire**

NAME \_\_\_\_\_ DATE \_\_\_\_\_



**PLEASE MARK THE AREAS OF YOUR COMPLAINT OR SYMPTOMS**

1. What are the reasons for your visit today? Evaluation Only Pain Relief Care Only Injury Treatment Posture Correction  
Spinal Rehabilitation Other \_\_\_\_\_

2. What do you hope that Smith Chiropractic can do for you? \_\_\_\_\_

3. What is your primary complaint today? \_\_\_\_\_

4. What other complaints would you like us to help you with? \_\_\_\_\_

5. How frequent are your symptoms? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

6. Please describe your complaint: Sharp Pain Dull Pain Diffuse Achy Burning Shooting Stiff Numbness & Tingling

7. Are your symptoms Getting worse Not changing Getting Better

8. Indicate intensity of your primary pain at its lowest and highest level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Pain)

9. Has your pain interfered with your work? Not at all A little bit Moderately Quite a bit Extremely Feel pain at work but doesn't affect it

10. Has your pain interfered with your social activities? Not at all A little bit Moderately Quite a bit Extremely

11. Have you been treated for this condition before? Yes No

If yes, by whom? Chiropractor Medical Doctor Physical Therapist Massage Therapist Other \_\_\_\_\_ Are you currently being seen? Yes No If so, How often and what treatments \_\_\_\_\_

12. When did your problem begin: GIVE SPECIFIC DATE IF POSSIBLE? \_\_\_\_\_

13. Describe how your problem began: \_\_\_\_\_

14. Do you consider this problem to be severe? Yes Yes, at times No

15. What aggravates your problem? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

16. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

17. Have you had episodes of this problem in the past? Yes No If so, how did you treat it then? \_\_\_\_\_

18. What concerns you the most about your problem? \_\_\_\_\_

**PAST HEALTH HISTORY**

Mark All That Apply:

Symptom	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Weight gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

**PRESENT HEALTH STATUS**

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight \_\_\_\_\_ lbs.

Tobacco Use:  Never  Infrequent 1/2 pack/wk  Moderate 1 pack/Day  Heavy 2+ Packs/Day

Alcohol Use:  Never  Infrequent 1-2 per wk  Moderate 3-5 per wk  Heavy 6+ per wk

Caffeine Use:  Never  Infrequent 1-2 per wk  Moderate 3-5 per wk  Heavy 6+ per wk

Drug/Medications: \_\_\_\_\_

Surgeries/Hospitalizations: \_\_\_\_\_

Previous Illnesses: \_\_\_\_\_

Previous Traumas: \_\_\_\_\_

**PRESENT HEALTH STATUS**

Please Check the appropriate boxes if there is a history of family illnesses:

Circle M for mother's side of family, F for father's side of family.

- |  |          |          |  |          |          |
|--|----------|----------|--|----------|----------|
| <input type="checkbox"/> Heart disease       | <b>M</b> | <b>F</b> | <input type="checkbox"/> Back Problems     | <b>M</b> | <b>F</b> |
| <input type="checkbox"/> High Blood Pressure | <b>M</b> | <b>F</b> | <input type="checkbox"/> Migraines         | <b>M</b> | <b>F</b> |
| <input type="checkbox"/> Lung Problems       | <b>M</b> | <b>F</b> | <input type="checkbox"/> Epilepsy/Seizures | <b>M</b> | <b>F</b> |
| <input type="checkbox"/> Arthritis           | <b>M</b> | <b>F</b> | <input type="checkbox"/> Allergies/Asthma  | <b>M</b> | <b>F</b> |
| <input type="checkbox"/> Diabetes            | <b>M</b> | <b>F</b> | <input type="checkbox"/> Cancer            | <b>M</b> | <b>F</b> |

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_