Back To Action Chiropractic Center Patient Health Questionnaire

Date _____ Patient Name _____

Is your visit today due to an accident? ☐ yes ☐ no *(If "Yes," also fill out the other side of this paper.)*

If this WAS NOT an Accident: Did your symptoms come on gradually? ☐ yes ☐ no
Date symptoms started: _____ **OR** Symptoms started _____ ☐ days ☐ weeks ☐ months ☐ years ago.

SYMPTOMS: Check all that apply and/or write in the blank.

☐ headache	☐ tension	☐ numbness in fingers	☐ cold sweats/fever	☐ diarrhea
☐ neck pain	☐ irritability	☐ numbness in toes	☐ face flushed	☐ feet cold
☐ neck stiffness	☐ chest pain	☐ shortness of breath	☐ buzzing in ears	☐ hands cold
☐ sleeping problems	☐ stomach upset	☐ fatigue	☐ loss of balance	☐ dizziness
☐ back pain	☐ head heavy	☐ light bothers eyes	☐ consitipation	☐ fainting
☐ nervousness	☐ pins and needles in arms	☐ depression	☐ loss of smell	☐ knee pain
☐ other:_____	☐ pins and needles in legs	☐ loss of memory	☐ loss of taste	☐ ears ring

Write out symptoms not listed: _____

Character and Quality of your pain: Please indicate where you have the pain, and how it feels.

Chief complaint: ☐ **Neck** ☐ **Mid back** ☐ **Low back** ☐ **Other:**_____

The PAIN is:	☐ Occasional	☐ Intermittent	☐ Frequent	☐ Constant
The SEVERITY is:	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
The QUALITY is:	☐ Dull	☐ Sharp	☐ Burning	☐ Stabbing
The LOCATION is:	☐ on the left	☐ on the right	☐ in the center	☐ equal on both sides

Secondary complaint: ☐ **Neck** ☐ **Mid back** ☐ **Low back** ☐ **Other:**_____

The PAIN is:	☐ Occasional	☐ Intermittent	☐ Frequent	☐ Constant
The SEVERITY is:	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
The QUALITY is:	☐ Dull	☐ Sharp	☐ Burning	☐ Stabbing
The LOCATION is:	☐ on the left	☐ on the right	☐ in the center	☐ equal on both sides

Tertiary complaint: ☐ **Neck** ☐ **Mid back** ☐ **Low back** ☐ **Other:**_____

The PAIN is:	☐ Occasional	☐ Intermittent	☐ Frequent	☐ Constant
The SEVERITY is:	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
The QUALITY is:	☐ Dull	☐ Sharp	☐ Burning	☐ Stabbing
The LOCATION is:	☐ on the left	☐ on the right	☐ in the center	☐ equal on both sides

I have difficulty:

☐ Standing	☐ Sitting	☐ Lying down	☐ Walking	☐ Riding in a car
☐ Rising after sitting	☐ Bending at waist	☐ Twist/ turn neck	☐ Twist/ turn back	☐ Lifting

The pain is WORSE in the: ☐ morning ☐ evening ☐ after light activity ☐ after heavy activity
The pain INTERFERES with: ☐ work ☐ sleep ☐ recreation ☐ Other:_____

The pain radiates into: ☐ Base of skull ☐ Neck ☐ Shoulders (L or R) ☐ Arms (L or R)
☐ Legs (L or R) ☐ Hips (L or R) ☐ Other: _____

Are you taking any medications for the pain? ☐ Aspirin ☐ Tylenol (acetominophen) ☐ Ibuprofen ☐ Other:_____

Accident Information

Date of Accident: _____

Type of Accident: ☐ Automobile ☐ Slip and Fall ☐ Job Related ☐ Athletic ☐ Other:_____

Address of Accident: _____

Street: _____ Nearest cross street: _____

If injuries are due to an **automobile accident**, please answer the following:

1. My vehicle ☐ was at fault ☐ was not at fault.

2. I was the: ☐ driver ☐ passenger

3. I was in the: ☐ front seat ☐ back seat

4. The vehicle I was in was headed: ☐ north ☐ south ☐ east ☐ west

5. The other car was headed: ☐ north ☐ south ☐ east ☐ west

6. The other vehicle struck me from: ☐ behind ☐ front ☐ right side ☐ left side
   OR
   My vehicle struck the other vehicle from: ☐ behind ☐ front ☐ right side ☐ left side

7. My vehicle was: ☐ moving ☐ stopped

8. Did any part of your body hit any part of your vehicle: ☐ yes ☐ no If yes, please indicate which body part and which vehicle part:_____
   _____

9. I was bruised: ☐ yes ☐ no Bleeding: ☐ yes ☐ no Unconcious: ☐ yes ☐ no

10. I was wearing my seatbelt: ☐ yes ☐ no

11. I received aid at the accident scene: ☐ yes ☐ no

12. The police were at the accident scene: ☐ yes ☐ no Were tickets issued? ☐ yes ☐ no To whom:_____

13. I have lost time from work: ☐ yes ☐ no

14. I was previously treated by another doctor for these injuries: ☐ yes, Dr. _____ ☐ no

15. I am presently under the care of another doctor for these injuries: ☐ yes, Dr. _____ ☐ no

16. I was taken to the hospital: ☐ yes ☐ no If yes, by whom (ambulance, friend, relative)?_____

17. On a scale of 1 to 10 describe how you felt... (1 = excellent, 10 = very bad)
    _____Before the accident
    _____During the accident
    _____Immediately after the accident
    _____Later the day of the accident
    _____The next day after the accident