MURRAY VALLEY CHIROPRACTIC CENTRE

Patient Health Questionnaire

Date:________________Name:______________________________________

Please briefly list any **current medical conditions**:______________________

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Please briefly list any **serious past medical conditions, serious injuries and surgery**: ____

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Are you currently taking any **medications / supplements**? **Yes** **No**

Please List: ____

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Have you **recently** had any of the following:

Fever / chills/ night sweats	Yes	No
Unintended weight loss	Yes	No
Excessive tiredness	Yes	No
Severe night pain	Yes	No
Pain that gets worse lying down	Yes	No
Pins and needles	Yes	No
Numbness of face or body	Yes	No
Pain with straining, coughing or sneezing	Yes	No

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Patient Health Questionnaire continued

Please circle YES or NO to all of the following questions and provide details as requested:

Do you suffer from:		
Diabetes Type 1 ☐ Type 2 ☐	**No**	**Yes** Managed by: ____________ Diet ☐ Tablets ☐ Insulin ☐
Strokes / mini strokes	**No**	**Yes**
Faints / blackouts / dizzy spells (please circle)	**No**	**Yes**
Epilepsy / fits / seizures	**No**	**Yes**
Blood disorders / bleeding problems / bruise easily	**No**	**Yes**
High blood pressure, high cholesterol or family history of heart disease (please circle)	**No**	**Yes**
Asthma	**No**	**Yes**
Bowel problems / disorders	**No**	**Yes**
Anxiety attacks / depression (please circle)	**No**	**Yes**
Medically diagnosed arthritis	**No**	**Yes** Specify: __________________
Osteoporosis	**No**	**Yes**
Cancer	**No**	**Yes**
Any other serious illness?	**No**	**Yes**
Do you or have you ever smoked?	**No**	**Yes** Date stopped: _____________ Current daily amount: _______
Do you drink alcohol?	**No**	**Yes**
Female patient – could you be Pregnant?	**No**	**Yes**
How would you rate the quality of your sleep? (please circle one (1) of the following) Good Interrupted Poor		

Please sign: ______________________________ Date: ____________________