



PATIENT HEALTH QUESTIONNAIRE

NAME WEIGHT HEIGHT AGE SEX

Check all boxes that apply.

Have you or any immediate family member ever been told you have:

	You	Family
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a history of:

- | | |
|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Ulcers |

Check all boxes that apply.

With current problem do you experience:

- | | |
|--|--|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Unexplained Weight Change | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Muscular Weakness |
| <input type="checkbox"/> Bowel or Bladder Changes | <input type="checkbox"/> Surgery |

For this problem have your received treatment from:

- | | |
|--|---|
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Other Physical Therapist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Other |

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections?

- No Yes
Describe:

Do you use caffeine?

- No Yes # of cups per day?

How often do you feel stress is a significant factor in your life?

- Never Seldom Regularly Always

List all medications and supplements:

.....
.....
.....

Date of last complete physical examination?

Do you smoke?

- No Yes How many packs?
- For how long?

List regular exercise/activity:

.....
.....
.....

Do you drink alcohol?

- No Yes # of drinks per week?

Other comments:

.....
.....



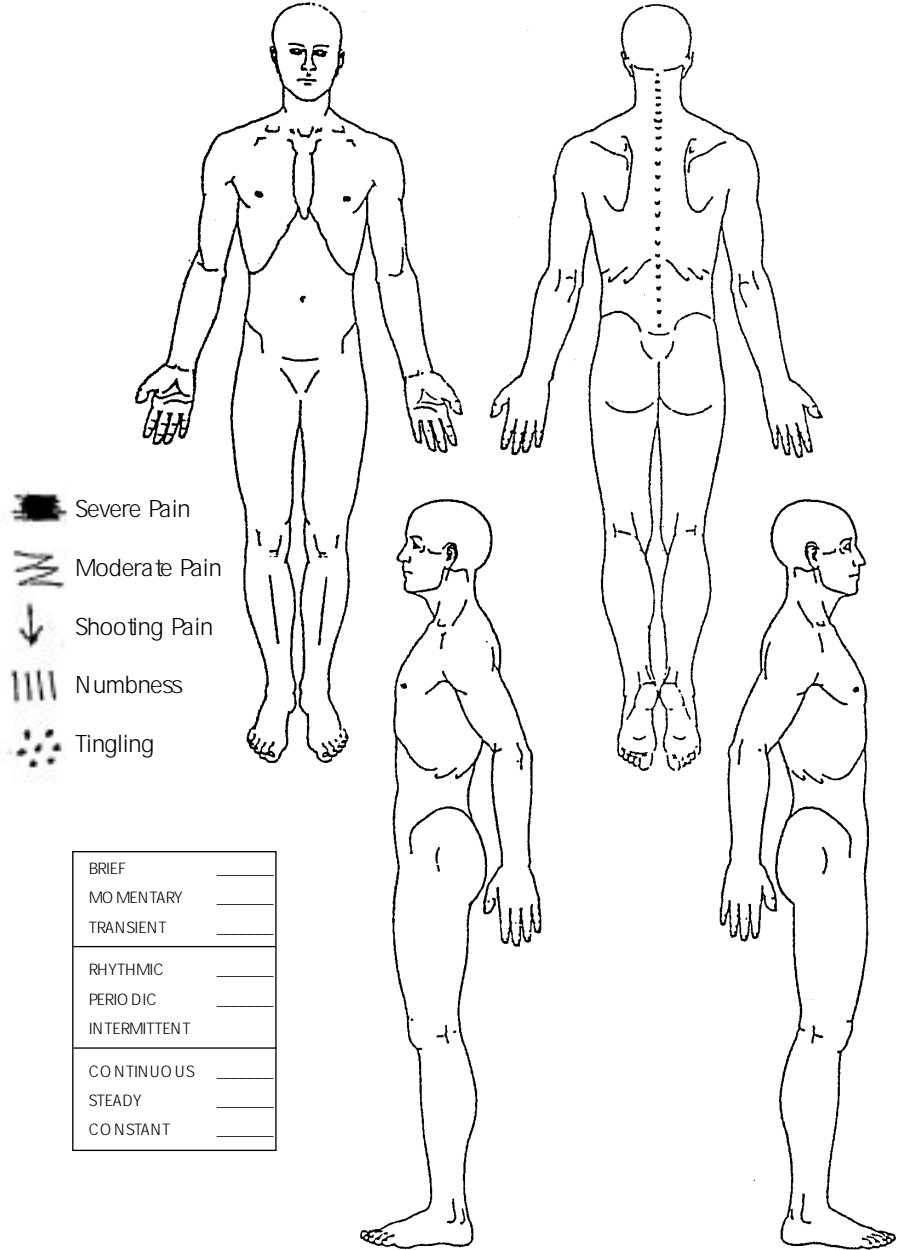
McGILL PAIN QUESTIONNAIRE

Patient Name

Date

DIRECTIONS: There are many words that describe pain. Some of these words are grouped below IF YOU ARE EXPERIENCING ANY PAIN, check (✓) any words that describe your pain.

1. Flickering _____ Quivering _____ Pulsing _____ Throbbing _____ Beating _____ Pounding _____	13. Fearful _____ Frightful _____ Terrifying _____
2. Jumping _____ Flashing _____ Shooting _____	14. Punishing _____ Grueling _____ Cruel _____ Vicious _____ Killing _____
3. Pricking _____ Boring _____ Drilling _____ Stabbing _____ Lancinating _____	15. Wretched _____ Blinding _____
4. Sharp _____ Cutting _____ Lacerating _____	16. Annoying _____ Troublesome _____ Miserable _____ Intense _____ Unbearable _____
5. Pinching _____ Pressings _____ Gnawing _____ Cramping _____ Crushing _____	17. Spreading _____ Radiating _____ Penetrating _____ Piercing _____
6. Tugging _____ Pulling _____ Wrenching _____	18. Tight _____ Numb _____ Drawing _____ Squeezing _____ Tearing _____
7. Hot _____ Burning _____ Scalding _____ Searing _____	19. Cool _____ Cold _____ Freezing _____
8. Tingling _____ Itchy _____ Smarting _____ Stinging _____	20. Nagging _____ Nauseating _____ Agonizing _____ Dreadful _____ Torturing _____
9. Dull _____ Sore _____ Hurting _____ Aching _____ Heavy _____	ACCOMPANYING SYMPTOMS: Nausea _____ Headache _____ Dizziness _____ Constipation _____ Diarrhea _____
10. Tender _____ Taut _____ Rasping _____ Splitting _____	ACTIVITY: Good _____ Some _____ Little _____ None _____
11. Tiring _____ Exhausting _____	SLEEP: Good _____ Fitful _____ Can't sleep _____
12. Sickening _____ Suffocating _____	FOOD INTAKE: Good _____ Some _____ Little _____ None _____



BRIEF	_____
MO MENTARY	_____
TRANSIENT	_____
RHYTHMIC	_____
PERIO DIC	_____
INTERMITTENT	_____
CONTINUOUS	_____
STEADY	_____
CO N STANT	_____

No Pain | _____ | Worst Possible Pain

11. Tiring _____ Exhausting _____	ACTIVITY: Good _____ Some _____ Little _____ None _____	SLEEP: Good _____ Fitful _____ Can't sleep _____	FOOD INTAKE: Good _____ Some _____ Little _____ None _____	COMMENTS:
12. Sickening _____ Suffocating _____				