Dr. Donald E. McGriff, DC MUAC

PATIENT HEALTH QUESTIONNAIRE

Personal Information Date:____

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Marital Status: S M D W Name of Spouse: _____
Phone: _____ Cell: _____
Work: _____ ext._____ Ok to call at work? Yes/No
Occupation: _____ Employer: _____
Business Address: _____

Who Referred You To Our Office or How Did You Hear About Us? _____

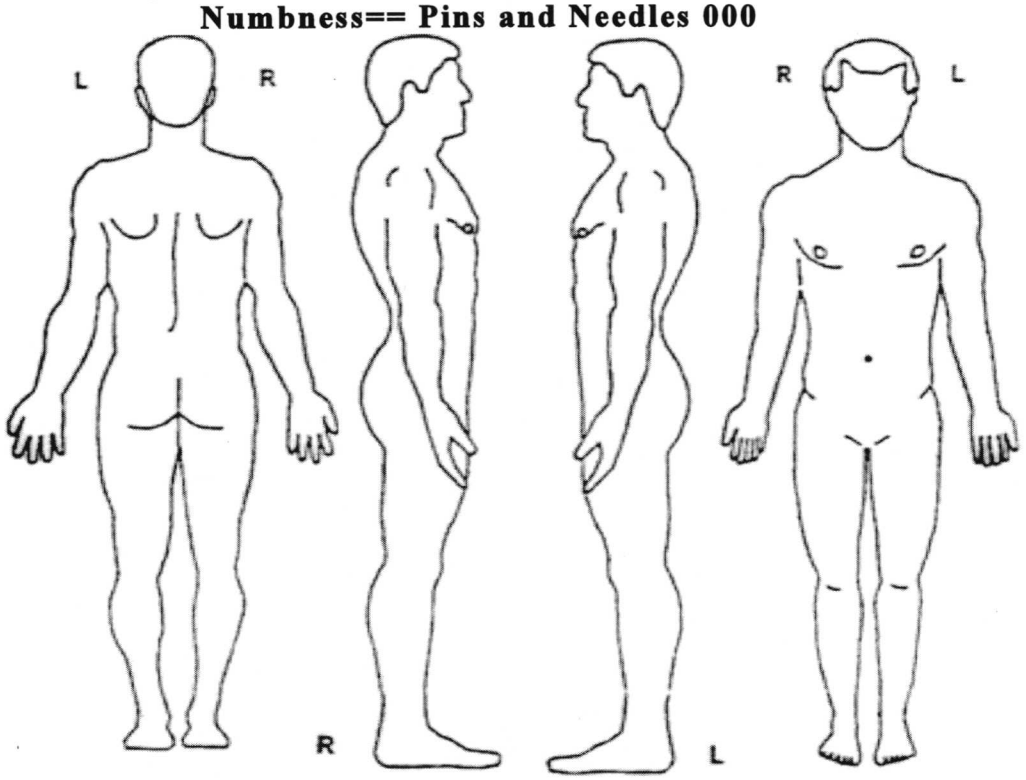
Have You Had Chiropractic Care? No/Yes; if so please indicate when and doctors name:_____

Date of Your Last Physical Examination: _____ Primary Doctor: _____

Current Complains

Use these symbols to describe the type of pain or sensations you are feeling:

Aching>>> Stabbing or Sharp pain /// Burning Pain XXX
Numbness== Pins and Needles 000



451 Hungerford Dr Suite 510 Rockville, MD 20850 (301) 738-1148

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Patient's Name: _____ Date: _____

CHIEF COMPLAINTS: _____

_____

DETAILS OF COMPLAINT

1. Did anything cause or contribute to the onset? Yes/No What? _____
2. When did the most recent episode begin? Date: _____
3. Have you sought other care for this condition? Yes/No Who? _____
4. Can you point to the exact location of your symptom(s)? .....Yes____ No____
5. How would you describe the intensity on a pain scale of 1 to 10? _____
6. Can you describe the sensation? _____ Yes ___ No_____ **(Dull, Sharp, Burning, Aching, Gnawing, Throbbing, Shooting, Constricting, Other)**
7. Has your condition been constant or intermittent through its duration? Yes/No Explain:_____
8. Does the pain radiate/travel to any part of your body? Yes/No Where? _____
9. Has there been changes in any bodily functions? Yes/No (**urination, bowel, respiration, digestion, vision, sexual, other)**
10. Has your condition been getting better, worse or about the same? _____
11. Has your condition affected your daily activities in any way? .....Yes/No How? _____
12. Is there anything that makes it worse? Yes/No What? _____
13. Have you found anything that makes it better? Yes/No What? _____
14. Have you tried store bought or home remedies? Yes/No What? _____

_____
Patient Signature

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DOCTOR'S NOTE

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