Dr. Abigail C. Cavallo
32 Lawrence Ave Suite 110, Smithtown, NY 11787

PATIENT HEALTH QUESTIONNAIRE

Name_____ Date_____

Please check all answers and fill in the blanks where appropriate. In the space below, please describe the major complaint which brought you to this office for care.

1. Major Complaint Description: (include related areas)

a. Area □head □neck □upper back □mid back □low back □shoulder □arm □hand □hip □leg □knee □foot

b. Location: □front □back □right □left □both sides □other (specify)_____

c. Description: □ sharp pain □ dull pain □ache □weak □throbbing □numb □shooting □gripping □burning □ tingling

d. Frequency: □ constant (76-100%) □ frequent (51-75%) □ occasional (26-50%) □ intermittent (25% or less)

e. Intensity:

no pain 1 2 3 4 5 6 7 8 9 10 unbearable pain

2. Describe how you current episode began: □ Uneventfully □ Gradually over time □ After specific incident

a. If from a fall, how many feet did you fall?_____

Did you land on □ Right □ Left □ Head □ Shoulder □ Middle Back □ Low Back □ Other_____

b. If from lifting, how many lbs?_____ and in what position were you?

□ bent forward □ bent backward □ knees bent □ twisted

Did you lift □ once □ a few times □ many times? Additional information?_____

3. Since current episode began on _____ has it □ decreased □ not changed □increased?
date

(if you don't know the specific date approximately how many _____weeks _____months_____years?)

4. What doctors/providers have you seen for this episode? □ DC □ MD □ DO □ PT □ None □Other_____

Examinations included: □ X-Rays _____ □ MRI _____ □ Other/results_____
date date

5. Treatment for this episode has included: □ Chiropractic _____ □ Exercise therapy □ heat □ cold (ice)

□ physical therapy_____ □ electrical therapy □ spinal injection_____ □ support/brace

□ surgery: describe_____ □ prescribed medication: list _____ □ OTC meds _____

6. In the past, have you been treated for a similar problem? □ Yes □ No If Yes, when?_____

What treatment helped?_____ Type of provider seen?_____

7. What makes your problem better/worse?

□ nothing □ lying down □ walking □ standing □ sitting □ movement/exercise □inactivity

8. How would you rate your general stress level? □ little or no stress □ minimal stress □ moderate stress □ greatly stressed

9. Physical activity at work: □sitting more that 50%of the day □light manual labor □manual labor □heavy manual labor □repeated motion

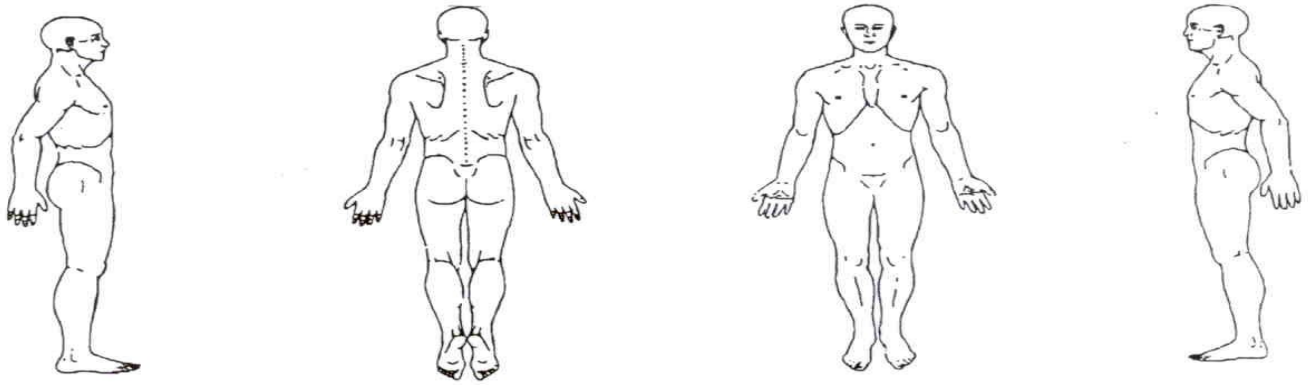
10. General physical activity:

□ no regular exercise program □ light exercise program □ moderate exercise program □ strenuous exercise program

11. Are your complaints affecting your ability to work or otherwise be active?

□ no effect
□ some physical restrictions (able to perform light duty & household tasks)
□ need limited assistance w/ common everyday tasks
□ need assistance often
□ significant inability to function w/out assistance
□ am totally disabled (impaired), and cannot care for self
□ cannot perform usual work duties
□ cannot work at all

Mark an X on the picture where you have pain or other symptoms as described in the major complaint description above.



Patient's Signature_____ **Date** _____