Dr. Veronica Yu
Chiropractor
(519) 281 3468
DrYu.ca

Patient Health Questionnaire

In order that the Doctor may get a complete picture of your health, please answer the following questions. All information will be treated as confidential

Name: _____ Address:

Phone Number (Home):
(Work):
(Cell):

Date of Birth: _____ Age:

Medical Doctor:

Family Health
Some diseases have a tendency to occur in families. Please fill in the following chart:

	Age	Health Problems	If Deceased, Age and Cause of Death
Father			
Mother			
Siblings			
Children			

Personal Habits

Dietary Intake (Amount per Day)
Alcohol _____ Tobacco _____ Coffee _____
Tea _____ Cola _____ Non-presciption Drugs _____

Do you sleep well? Y/N

What position do you sleep in (Please Circle) Back Stomach Side

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Do you participate in an regular exercise program? Y/N

Medications, including aspirin, birth control or other over the counter pharmaceuticals:

Prior car accidents or significant injuries. Please state when and describe the injuries or any physical limitations resulting:

Any surgeries, including approximate dates and any resulting complications:

If you are employed, please state your occupation and describe what activities you do on a daily basis (e.g. Bending, lifting, twisting, typing, prolonged sitting or standing):

Have you ever had x-rays taken of your spine? Y/N If yes, when?

Have you ever been treated by a Chiropractor? Y/N If yes, who have you seen in the past and when was the last treatment you received?

Do you have any diagnosed medical conditions (e.g. Diabetes, high blood pressure, arthritis, cancer etc)?

Do you consider yourself to be under stress (e.g. Marital, workplace, domestic, financial)?

On what area(s) of your body would you like to focus your therapy?

Pain Severity Scale:
Rate your level of pain today by checking one box on the following scale

0	1	2	3	4	5	6	7	8	9	10
No Pain									Excruciating Pain	

Today's Date: _____ Your Signature: