



Chiropractic Clinic

Patient Health Questionnaire

401 South Main Street, Suite 104
Blacksburg, VA 24060

540.552.5202 • www.southmainchiro.com

Date: _____

Last Name _____ First Name _____ M.I. _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Date of Birth _____ Age _____ Gender: Male Female

Occupation _____ Employer _____

Health Care Plan Provider (if applicable) _____

Are you new to South Main Chiropractic? Yes No

How did you hear about our clinic? _____

Height _____ Ft. _____ In. Weight _____ Lbs.

What brings you to the clinic?

What is your primary complaint?

Is your injury related to an auto accident? (circle) Yes No

Is your injury work related? (circle) Yes No

Please describe the circumstances of your complaint:

Please describe your complaint (circle all that apply)

Sharp Pain Throbbing

Dull Pain Numbness/Tingling

Ache Shooting

Weak Burning

Please describe the frequency of your complaint (circle)

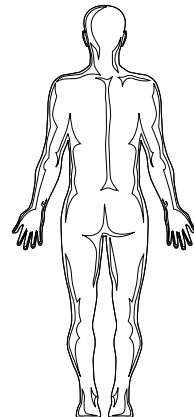
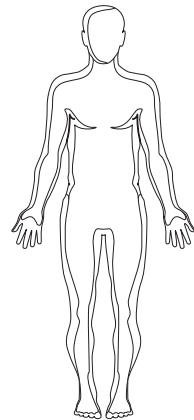
Constant (76%) Occasional (26-50%)

Frequent (51-75%) Intermittent (25% or less)

Indicate intensity of your pain at its lowest and highest level

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

Areas of Complaint



Please mark the area of your complaint and/or symptoms by circling or shading the example.

