Dr. Peggy Malone

Chiropractor 519-808-9341
drpeggymalone.com/chiropractic-services

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(s) (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-prescription 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 a 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?

_____

<u>Pain Severity Scale:</u>
Rate your level of pay 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: _____

