BEACON
Orthopaedics & Sports Medicine

PATIENT HEALTH QUESTIONNARE

Dr. Jaideep Chunduri

Name: _____ Date: _____

DOB: _____ Age: _____ Weight _____ Height _____

Name of Family Doctor: _____

How were you referred to this office?

- ☐ Advertisement
- ☐ Attorney
- ☐ Case Manager
- ☐ Name (Optional) _____
- ☐ Chiropractor
- ☐ Employer
- ☐ Family Physician
- ☐ Self
- ☐ Specialty Physician
- ☐ Occupational Medicine Clinic
- ☐ Other: _____

FRONT VIEW

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Numbness = = =

Constant / Throbbing Ache x x x x x x

Increased Sensitivity OOO OOO

Sharp Twinge with Motion / / / / / /

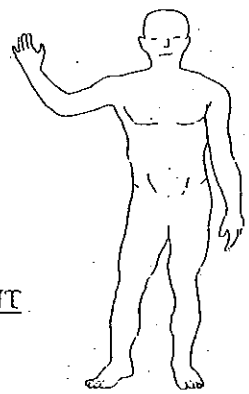
BACK VIEW

Mark below on the scale from 0 to 100 your level of discomfort with 0 being none and 100 being unbearable

None — Unbearable

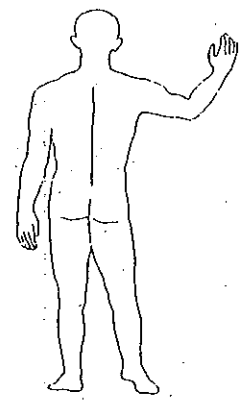
0 — 100

R L



FRONT

L R



BACK

What treatments have been prescribed?

- ☐ None
- ☐ Acupuncture
- ☐ Brace
- ☐ Injections
- ☐ Manipulation
- ☐ Massage Therapy
- ☐ Pain Management Program
- ☐ Pain Medication
- ☐ Physical Therapy
- ☐ Work Hardening Program
- ☐ Other: _____

What testing has been done?

- ☐ None
- ☐ Blood Tests
- ☐ Bonescan
- ☐ CT scan
- ☐ DEXA scan
- ☐ Discography
- ☐ EMG/NCV
- ☐ Functional Capacity Testing
- ☐ MRI
- ☐ Myelogram
- ☐ X-Rays
- ☐ Other: _____

Describe your level of stress:

- ☐ None
- ☐ Low
- ☐ Medium
- ☐ High
- ☐ Very high

Have you had any of the following symptoms or conditions?

- ☐ Abdominal pain/heartburn
- ☐ Chronic pain
- ☐ Difficulty swallowing
- ☐ General fatigue
- ☐ Hearing impairment
- ☐ Impaired coordination
- ☐ Impaired sexual function
- ☐ Impaired sleep patterns
- ☐ Loss of bladder/bowel control
- ☐ Vision/balance changes
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss