Patient Health Questionnaire - PHQ

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

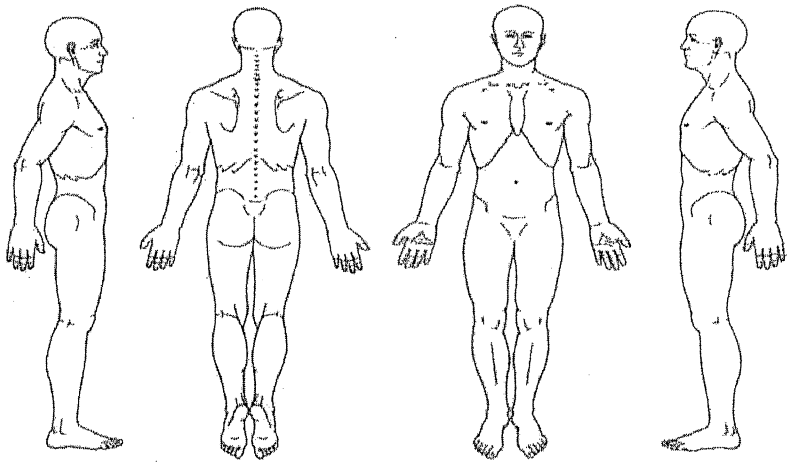
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ ***Date*** _____

Please list all **medications** you are taking with **dosages** (if applicable). Including over the counter medications.

Do you now have or have you ever had any of the following?

□ Asthma, Bronchitis, Emphysema, COPD
□ Shortness of breath/chest pain
□ Coronary Heart Disease or Angina
□ Pace Maker/Defibrillator
□ High Blood Pressure
□ Heart Attack/Surgery
□ Stroke/TIA
□ Congestive Heart Disease
□ Blood Clot/Emboli/DVT
□ Epilepsy/Seizures
□ Thyroid Disease or Goiter
□ Anemia
□ Diabetes
□ Infectious Disease
□ Cancer/Chemotherapy/Radiation
□ Unexplained Weight loss/Energy loss
□ Unexplained Night pain
□ Osteoporosis
□ Arthritis
□ Severe or frequent headaches
□ Vision/Hearing difficulties
□ Numbness or tingling
□ Dizziness or fainting
□ Sleeping problems/difficulties
□ Bowel or Bladder Problems
□ Weakness
□ Hernia
□ Varicose Veins
□ Allergies
□ Pins or Metal Implants/ Joint Replacement
□ Neck injury/Surgery
□ Back injury/Surgery
□ Shoulder injury/Surgery
□ Knee injury/Surgery
□ Gout
□ Pregnant
□ Use Tobacco

Parent/Guardian Signature:	Date: