Welcome

Thank you for choosing Valir as your health care provider!

Patient Health Questionnaire – PHQ

Patient Name: ______________________________

DOB: ______________________________________

Referring Physician: _________________________

Primary Care Physician: _____________________

1) Describe your symptoms:
   ____
   ____
   a. When did your symptoms start?
      ____
   b. How did your symptoms begin?
      ____

2) How often you experience your symptoms. **(circle one)**
   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)

3) How are your symptoms changing? (**circle one**)
   1. Getting Better
   2. Not Changing
   3. Getting Worse

4) During the past (4) weeks:
   a. Indicate current pain level:
      0 1 2 3 4 5 6 7 8 9 10
   b. Indicate minimum pain level:
      0 1 2 3 4 5 6 7 8 9 10
   c. Indicate maximum pain level:
      0 1 2 3 4 5 6 7 8 9 10

5) How much has pain interfered with your normal work, inside and outside the home? (**circle one**)
   1. Not at all   3. Quite a bit   5. Extremely
   2. A little bit   4. Moderately

6) How much has your condition interfered with social activities? (**circle one**)
   1. Not at all   3. Quite a bit   5. Extremely
   2. A little bit   4. Moderately

7) What describes the nature of your symptoms? (**circle all that apply**)
   1. Sharp   3. Shooting   5. Dull Ache
   2. Burning   4. Numb   6.Tingling

8) In general, would you say your overall health right now is: (**circle one**)
   1. Excellent   3. Fair
   2. Very Good   4. Poor

9) Who have you seen for your symptoms? (**circle all that apply**)
   1. No One   3. Chiropractor   5. Other
   2. PT   4. MD
   a) What treatment did you receive and when?
      ____
   b) What tests have you had for your symptoms and when?
      ____

10) Have you had similar symptoms in the past? (**circle one**) Yes // No

11) What is your expected outcome from physical therapy?
    ____

12) What is your occupation? ____________________
    (**circle one**)
    FT   PT   Unemployed   Retired   Off Work

13) Current Weight: _______ Height: _______

Patient Signature:

____

Date: ______________________________________