

PATIENT HEALTH QUESTIONNAIRE-PHQ

Patient Name: _____

Date: _____

File# _____

1. **Describe your symptoms** _____

_____.

- a. When did your symptoms start? _____.
- b. How did your symptoms begin? _____.
- c. What activities cause pain? _____.
- d. What activities can you not do because of the pain? _____.
- e. What aggravates your condition? _____.
- f. What relieves your symptoms? _____.

2. **How often do you experience your symptoms?**

- a. Constantly (76-100% of the day)
- b. Frequently (51-75% of the day)
- c. Occasionally (26-50% of the day)
- d. Intermittently (0-25% of the day)

3. **How are your symptoms changing?**

- a. Getting Better
- b. Not changing
- c. Getting worse

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on the body below where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache: A A A A A

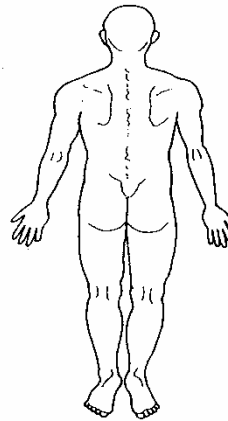
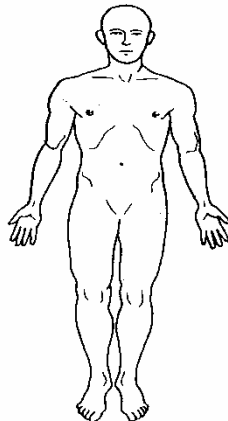
Numbness: N N N N N

Pins & Needles: P P P P P

Burning: B B B B B

Stabbing: S S S S S

Throbbing: T T T T T



4. **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

5. **During the past four (4) weeks how much of the time has your condition interfered with social activities?**

- 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

Patient Signature _____

Date _____

Patient Name _____

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

- 1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

7. Who have you seen for your symptoms?

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

a. What treatment did you receive and when? _____

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

- 1. X-rays (Date: _____) 2. MRI (Date: _____) 3. CT Scan (Date: _____) 4. Other (Date: _____)

8. 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 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

9. What is your occupation?

- 1. Professional/Executive 2. White Collar/Secretarial 3. Tradesperson 4. Laborer
- 5. Homemaker 6. FT Student 7. Retired 8. Other (Specify: _____)

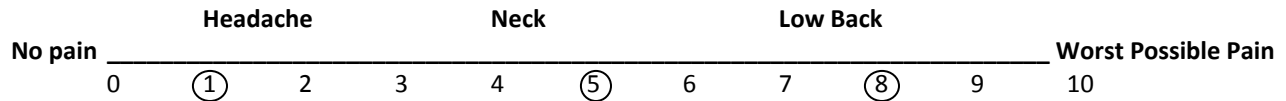
a. If you are not retired, a homemaker, or a student, what is your current work status?

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

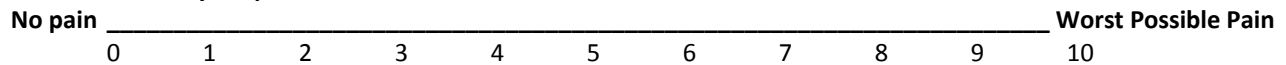
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

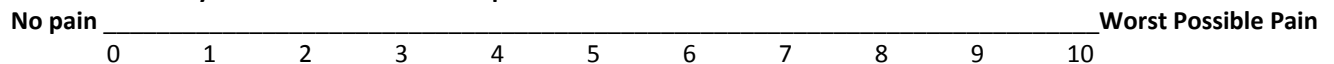
Example:



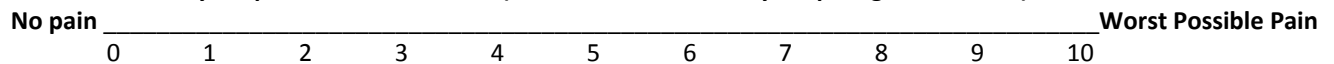
1. What is your pain RIGHT NOW?



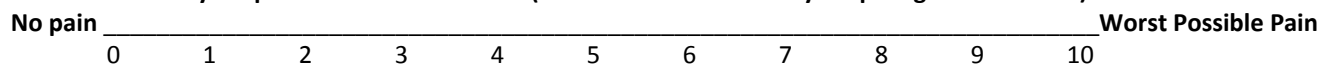
2. What is your TYPICAL or AVERAGE pain?



3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



File# _____

What type of regular exercise do you perform? 1. None 2. Light 3. Moderate 4. Strenuous

What is your height and weight? Height (Feet _____ Inches _____) Weight (Lbs. _____)

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Prod.
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependency
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Cancer		
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/>	<input type="checkbox"/> Tumor		
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Asthma		
		<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis		

Females Only

<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Pregnancy

Other Health Problems/Issues

<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/> _____

Indicate if an immediate family member has had any of the following:

- | | | | | | |
|-------------------------|-------------------|-------------|-----------|-----------|----------|
| 1. Rheumatoid Arthritis | 2. Heart Problems | 3. Diabetes | 4. Cancer | 5. Stroke | 6. Other |
|-------------------------|-------------------|-------------|-----------|-----------|----------|

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ **Date** _____

Doctor's Additional Comments:

Doctor's Signature _____ **Date** _____