

PATIENT HEALTH QUESTIONNAIRE – PHQ
(All Questions Must Be Answered)

Patient Name: _____ DOB: _____ Date: _____

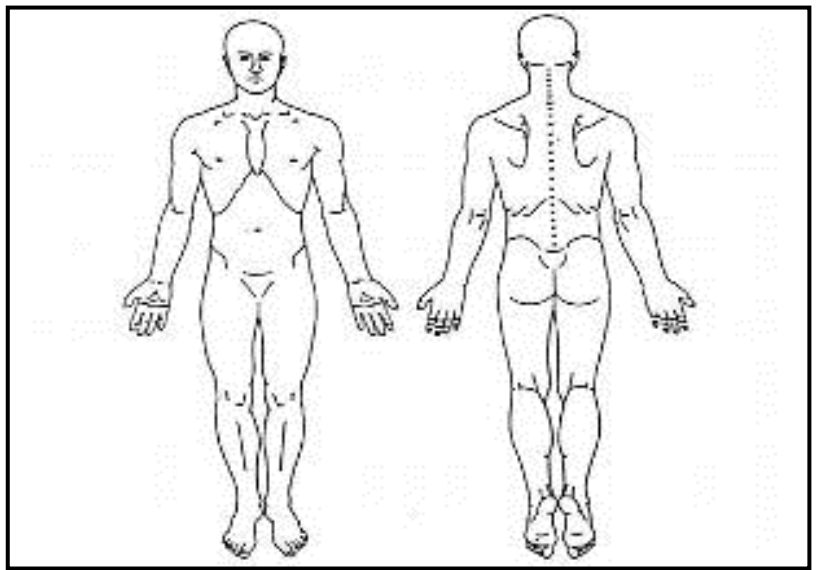
1. When did your symptoms start? ___/___/___ _____
2. Describe your symptoms: _____

3. What is your goal for therapy? _____

4. How often do you experience your symptoms?

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

**Indicate where you have pain or other symptoms:
(MARK PICTURE WHERE YOU HAVE PAIN)**



5. What describes the nature of your symptoms?

(Check all that apply)

- Sharp Shooting
 Dull Ache Burning
 Numb Tingling

6. How are your symptoms changing?

(Check one below)

- Getting better
 Not changing
 Getting worse

7. Your symptoms are worse in the:

- Morning Increased during the day
 Afternoon Night Same all day

What movement causes the pain to increase? _____

During the past 4 weeks: (Circle to indicate)

Indicate the intensity of pain at rest: **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

Indicate the intensity of pain with movement: **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

8. How much has it interfered with your normal work (including home and housework)? (Check one below)

- None of the time A little bit Moderately Quite a bit Extremely

9. What makes your problem better?

(Check all that apply)

- Nothing Standing Movement/Exercise
 Lying Down Sitting Inactivity

10. What makes your problem worse?

(Check all that apply)

- Nothing Standing Movement/Exercise
 Lying Down Sitting Inactivity

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11. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(Example: visiting with friends, relatives, etc.) (Check one below)

___ All the time ___ Most of the time ___ Some of the time ___ A little of the time ___ None of the time

12. In general would you say your overall health right now is... (Check one below)

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

13. Who have you seen for your symptoms? (Check one below)

___ No One ___ Chiropractor ___ Medical Doctor ___ Physical Therapist ___ Other _____

What treatment did you receive and when? _____

14. What tests have you had for your symptoms and when were they performed? (Check one below)

___ X-rays date: _____ ___ CT Scan date: _____

___ MRI date: _____ ___ Other date: _____

Did you have surgery? ___ Yes ___ No Date of Surgery if applicable: ___/___/___

15. Have you had similar symptoms in the past? ___ Yes ___ No

If you have received treatment in the past for the same similar symptoms, who did you see? (Check one below)

___ No One ___ Chiropractor ___ Medical Doctor ___ Physical Therapist ___ Other _____

16. What is your occupation? ___ Professional/Executive ___ Laborer ___ Retired

(Check all that apply) ___ White Collar/Secretarial ___ Homemaker ___ Tradesperson

___ FT Student ___ Other _____

a) If you are not retired, a homemaker, or a student, what is your current work status? (Check all that apply)

___ FT ___ PT ___ Self-Employed

___ Unemployed ___ Off Work ___ Other

Please check off if you have had any of the conditions listed below:

___ High blood pressure ___ Epilepsy

___ Angina ___ Diabetes

___ Heart attack ___ Rheumatoid Arthritis

___ Stroke ___ Arthritis

___ Asthma ___ Pregnancy

___ HIV/AIDS ___ Other _____

___ Tumor ___ Tobacco packs/day ___

___ Systemic Lupus ___ Drug or Alcohol Dependence

___ Hepatitis ___ Coffee/Tea/Caffeine drinks: cups/cans per day ___

___ Cancer Location: _____ Date: ___/___/___

Present: Weight _____ Height: Feet _____ Inches _____

Hospitalization/Surgical Procedures (list if not described elsewhere): _____

Medications: _____