

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

Patient Name: _____ DOB: _____ Date: _____

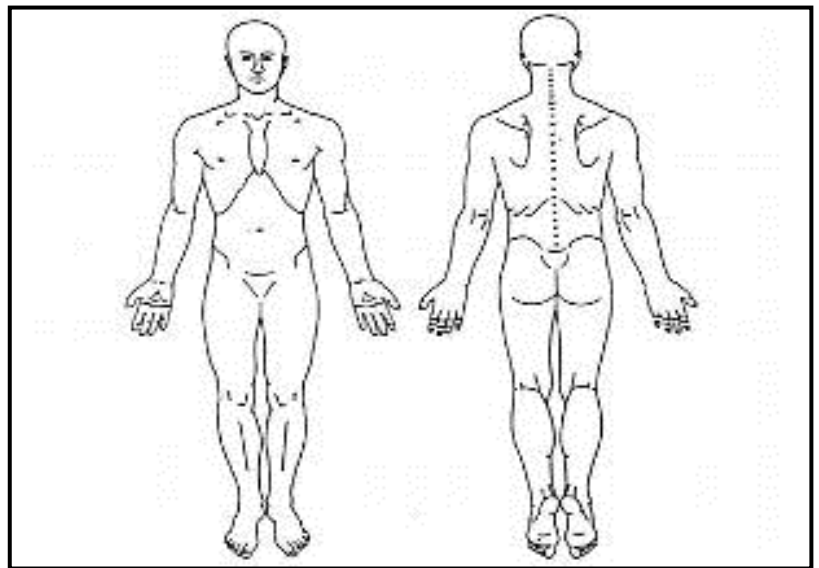
1. When did your symptoms start? ___/___/___ _____
2. Describe your symptoms: _____

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: _____