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

Patient Name:_____ **DOB**: _____ **Date:** _____

Present: Weight _____ Height: Feet_____ Inches _____

1. When did your symptoms start? ___/___/___

2. Describe your symptoms: _____

_____

_____

3. What is your goal for therapy?_____

_____

4. During the past 4 weeks: (Circle to indicate)

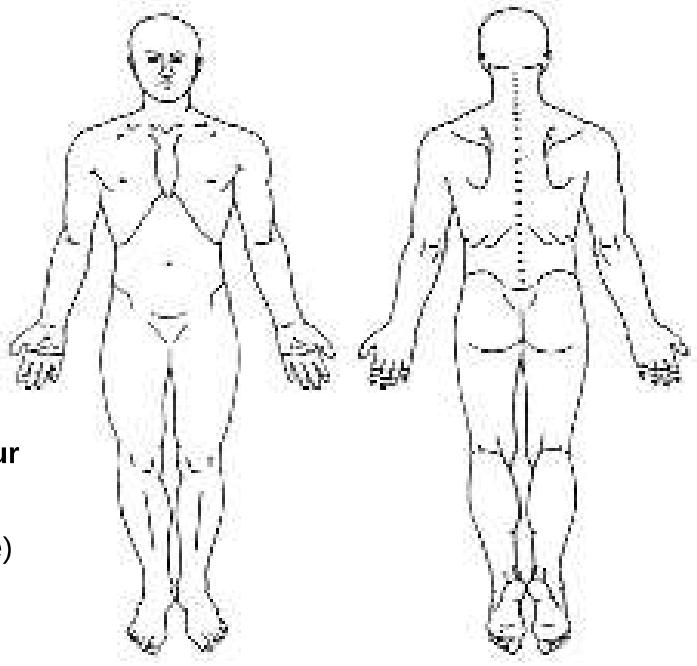
Indicate the intensity of pain at rest: **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

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

5. What describes the nature of your symptoms?
(Check all that apply)

___ Sharp ___ Shooting ___ Throbbing
___ Dull Ache ___ Burning ___ Spasms
___ Numb ___ Tingling ___ Weakness

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



6. 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)

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

_____ None of the time ___ A little bit ___ Moderately
_____ Quite a bit ___ Extremely

8. 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)

___ All the time ___Most of the time ___Some of the time
___ A little of the time ___ None of the time

9. How are your symptoms changing since the onset?
(Check one below)

___ Getting better ___ Not changing ___ Getting worse

10. Your symptoms are worse in the:

___ Morning ___ Increased during the day ___ Night ___ Same all day ___ Afternoon

11. What movement causes the pain to increase?

_____

Patient Name:_____ **DOB**: _____ **Date:** _____

12. What makes your problem better? (Check all that apply)
___ Nothing ___ Standing ___ Movement/Exercise
___ Lying Down ___ Sitting ___ Inactivity
_____ Other

13. What makes your problem worse? (Check all that apply)
___ Nothing ___ Standing ___ Movement/Exercise
___ Lying Down ___ Sitting ___ Inactivity
_____ Other

14. In general would you say your overall health right now is… (Check one below)
___ Excellent ___Very Good ___ Good ___ Fair ___ Poor

15. Who have you seen for your symptoms?
___ No One ___ Chiropractor ___ Medical Doctor ___ Physical Therapist ___ Other _____
What treatment did you receive and when? _____

16. What tests have you had for your symptoms and when were they performed?
____ X-rays date: _____ ____CT Scan date:_____
____ MRI date: _____ ____Other date:_____
Did you have surgery? ___ Yes ___No Date of Surgery if applicable: ____/____/____

17. 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?
___ Chiropractor ___ Medical Doctor ___ Physical Therapist ___ Other _____

18. What is your occupation? ___ Professional/Executive ___ Laborer ___ Retired
___ 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?
___ FT ___ PT ___Self-Employed
___ Unemployed ___ Off Work ___ Other

Please check off if you have had any of the conditions listed below:
____ High blood pressure
____ Angina
____ Heart attack
____ Stroke
____ Asthma
____ HIV/AIDS
____ Tumor
____ Systemic Lupus
____ Hepatitis
____ Cancer Location: _____
____ Epilepsy
____ Diabetes
____ Rheumatoid Arthritis
____ Osteo Arthritis
____ Other _____
____ Tobacco packs/day ____
____ Drug or Alcohol Dependence
____ Coffee/Tea/Caffeine drinks: cups/cans per day ____
____ Are you pregnant YES NO

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

Medications: _____