Patient Health Questionnaire – PHQ

Patient Name_____ ***Date***_____

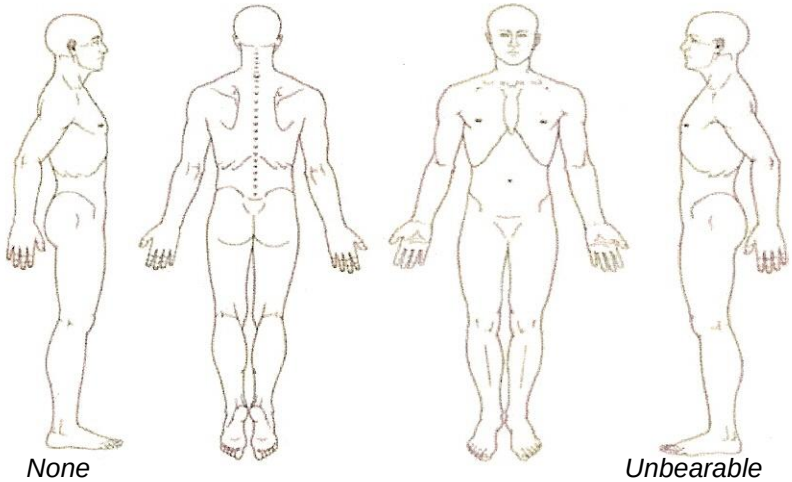
1. Describe your symptoms _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?
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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
1. Sharp
2. Dull ache
3. Numb
4. Shooting
5. Burning
6. Tingling

4. How are your symptoms changing?
1. Getting better
2. Not changing
3. Getting worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None 0 1 2 3 4 5 6 7 8 9 10 *Unbearable*

b. How much has the 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

6. During the past four weeks, how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)
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

7. In general would you say your overall health right now is…
1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

8. Who have you seen for your symptoms?
1. No One 3. Medical Doctor 5. Other
2. Chiropractor 4. Physical Therapist 6. _____

9. **Have you had surgery for this problem?** If so, the surgery date_____

b. What tests have you had for your symptoms and when were they performed?
1. X-rays date: _____ 3. CT Scan date: _____
2. MRI date: _____ 4. Other date: _____

c. Have you received physical therapy this year? _____ How many visits?_____

d. Medicare Patients – Are you currently receiving Home Health Care? _____Yes _____ No

10. 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 3. Medical Doctor 5. Other
2. Chiropractor 4. Physical Therapist _____

11. Do you have any family members who have had similar physical difficulties?_____

12. What is your occupation?
1. Professional/Executive 4. Laborer 7. Retired
2. White Collar/Secretarial 5. Homeworker 8. Other
3. Tradesperson 6. FT Student

13. How did you find us? Radio / Print Advertisement / Website / Facebook /Twitter / Previous Patient /Doctor

Patient Signature_____***Date***_____