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

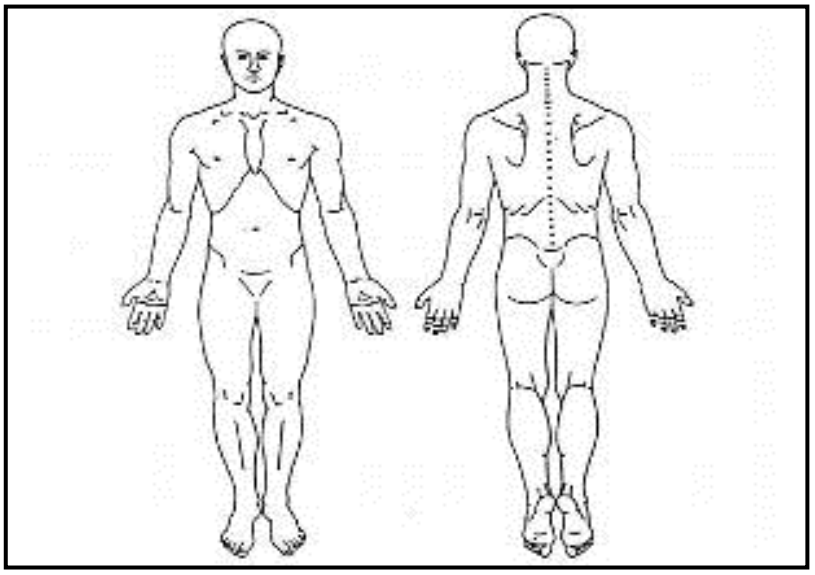
Patient Name: _____ **DOB**: _____ **Date:** _____

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?** ___ Nothing ___ Standing ___ Movement/Exercise
   (Check all that apply) ___ Lying Down ___ Sitting ___ Inactivity

10. **What makes your problem worse?** ___ Nothing ___ Standing ___ Movement/Exercise
    (Check all that apply) ___ 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: _____

_____

_____