Patient Health Questionnaire – PHQ

Patient Name _____ Date _____

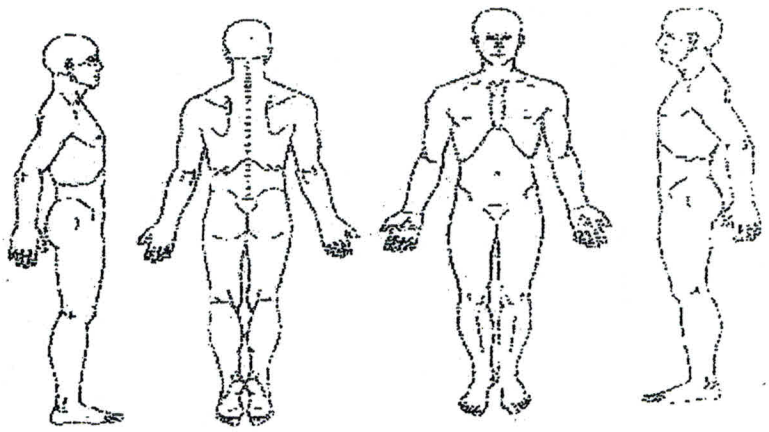
1. **Describe your symptoms** _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



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 pain interfered with your normal work (including both work outside the home, housework)
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

6. What makes symptoms better? _____

7. What makes symptoms worse? _____

8. During the **past 4 weeks** how much of time has your condition interfered with social activities *(like visiting with friends, etc)*
   1. Not at all 2 Most of the time 3. Some of the time 4. A little of the time 5. None of the time

9. In general would you say your overall heath right now is.... 1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

10. Who have you seen for your symptoms? 1. No one 2. MD 3. Chiropractor 4. Physical Therapist 5. Other

    a. What treatment did you receive and when? _____

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

11. 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 2. MD 3. Chiropractor 4. Physical Therapist 5. Other

12. What is your occupation?_____ Professional/Executive Laborer Retired Homemaker White collar/secretary Tradesperson Ft Student Other

Patient Signature_____ Date:_____