Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

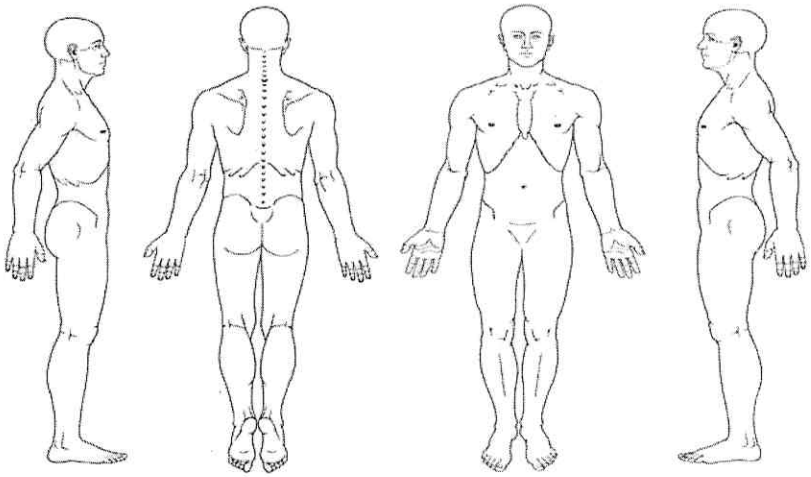
a. When did your symptoms start? _____

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 ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

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, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> 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

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8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. 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 Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

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If you have ever had a listed symptom in the past, please check that symptom in the ***PAST*** column. If you are presently troubled by a symptom, check that symptom in the ***PRESENT*** column.

Past	Present		Past	Present	
☐	☐	Neck pain (723.1)	☐	☐	Irregular menstrual flow (626.41)
☐	☐	Shoulder pain (719.41)	☐	☐	Profuse menstrual flow (626.7)
☐	☐	Pain in upper arm or elbow (719.24)	☐	☐	Breast soreness/lumps (611.72)
☐	☐	Hand pain (719.44)	☐	☐	Vaginal discharge (623.5)
☐	☐	Upper back pain (724.1)	☐	☐	PMS (625.4)
☐	☐	Low back pain (724.2)	☐	☐	Loss of bladder control (788.30)
☐	☐	Pain in upper leg or hip (719.45)	☐	☐	Painful urination (788.1)
☐	☐	Pain in lower leg or knee (729.5)	☐	☐	Frequent urination (788.41)
☐	☐	Pain in ankle or foot (719.47)	☐	☐	Abdominal pain (789.0)
☐	☐	Jaw pain (526.9)	☐	☐	Constipation (564.0)
☐	☐	Swelling/stiffness of joint(s)	☐	☐	Difficulty swallowing (787.2)
☐	☐	Fainting, Visual Disturbance/Nausea	☐	☐	Heartburn/indigestion (787.1)
☐	☐	Convulsions (780.3)	☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Dizziness (780.4)	☐	☐	Tobacco use (305.1)
☐	☐	Headache (784.0)	☐	☐	Alcohol use (305.0)
☐	☐	Muscular Incoordination (781.3)	☐	☐	Birth control pills used
☐	☐	Tinnitus (ear noise) (388.30)	☐	☐	Medications (please list them):
☐	☐	Rapid heart beat (785.0)			_____
☐	☐	Chest pains (786.50)			_____
☐	☐	Loss of appetite (783.0)			_____
☐	☐	Anorexia (783.0)	☐	☐	Drug or alcohol dependence
☐	☐	Abnormal weight ☐ Gain (783.1)		☐	Pacemaker – how long? _____
		☐ Loss (783.2)	☐	☐	Surgical procedures (please list):
☐	☐	Excessive thirst (783.5)	☐	☐	_____
☐	☐	Chronic cough (786.2)			_____
☐	☐	Chronic sinusitis (473.9)	☐	☐	Caffeine intake (soda, tea, coffee)
☐	☐	General fatigue (780.7)	☐	☐	cups per day _____
☐	☐	Depression (311)	☐	☐	Emphysema (492.8)
☐	☐	Aortic aneuysm (441.5)	☐	☐	Arthritis (716.9)
☐	☐	High blood pressure (401.9)	☐	☐	Diabetes (250.0)
☐	☐	Angina (413.9)	☐	☐	Ulcer (556.9)
☐	☐	Heart attack (410.9)	☐	☐	Kidney stones (592.0)
☐	☐	Stroke (436)	☐	☐	Bladder infection (595.9)
☐	☐	Asthma (436)	☐	☐	Kidney disorder (by condition)
☐	☐	Cancer (199.1)	☐	☐	Colitis (558.9)
☐	☐	Prostate problems (601.9)	☐	☐	Irritable colon (564.0)
☐	☐	Pregnancy	☐	☐	HIV/AIDS (042)
☐	☐	Blood disorder (790.6)	☐	☐	Other _____

Weight _____ lbs **Height** _____ feet _____ inches

Do you have a permanent disability rating?___ Y ___ N
Location _____ Rating percentage _____%
Date rating received _____/_____/_____

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer ☐ Lung Problems ☐ Headaches ☐ Lupus
☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Epilepsy
☐ Heart problems ☐ Back problems ☐ Other problems _____

Patient signature: _____ **Date:** _____

Print Name: _____