Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/16/05

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 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, and housework)

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

6. During the past 4 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 ② 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 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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Patient Name________________________________

MEDICAL HISTORY

Date of Birth: _____/_____/_____ **Gender:** ☐ M ☐ F ☐ Right-handed ☐ Left-handed

Please check if you have ever had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Arthritis (Osteoarthritis or Rheumatoid Arthritis)
- ☐ Blood Disorder
- ☐ Bowel Problems
- ☐ Breathing / Lung Problems
- ☐ Broken Bones
- ☐ Cancer
- ☐ Chest pain
- ☐ Circulation Problems
- ☐ Depression/Anxiety
- ☐ Diabetes / High Blood Sugar
- ☐ Dizziness or blackouts
- ☐ Epilepsy / Seizures
- ☐ Head Injury
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Skin Disorders
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Urinary Problems
- ☐ Other: ________________

Please check if you have experienced the following symptoms in the past year:

- ☐ Shortness of breath
- ☐ Loss of balance or falls
- ☐ Difficulty walking
- ☐ Difficulty dressing
- ☐ Difficulty lifting
- ☐ Difficulty sleeping
- ☐ Joint pain or swelling
- ☐ Weakness in arms or legs
- ☐ Vision problems
- ☐ Headaches
- ☐ Fever / Chills / Sweats
- ☐ Pain at night
- ☐ Weight loss/gain
- ☐ Nausea / Vomiting
- ☐ Coordination problems

Have you ever had surgery? ☐ Yes ☐ No If yes, please describe and provide date:

________________________________ Date: _____/____/______
________________________________ Date: _____/____/______
________________________________ Date: _____/____/______

Do you take any prescription or non-prescription medications? ☐Yes ☐ No If yes, please list below:

____
____

Do you: ☐ Smoke ______ppd ☐ Drink alcohol ______drinks/week
☐ Exercise _________times/week for _______minutes

Are you currently pregnant? ☐ Yes ☐ No