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?***

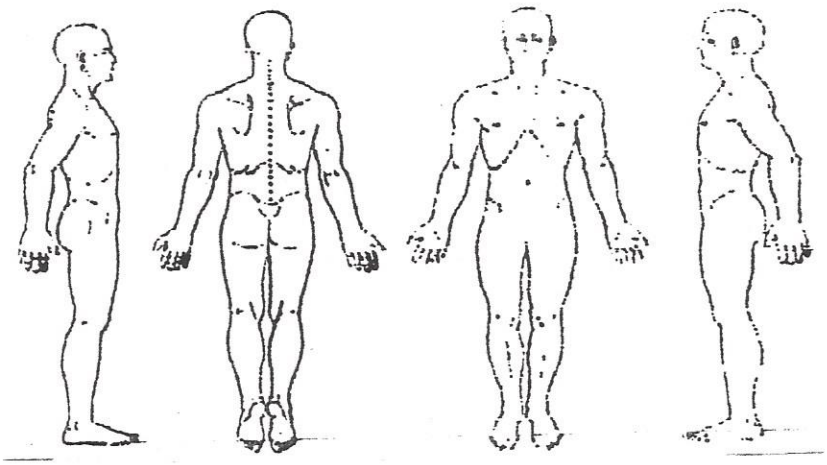
   ① Constantly (76-100% of the day)

   ② Frequently (51-75% of the day)

   ③ Occasionally (26-50% of the day)

   ④ Intermittently (0-25% of the time)

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:*** **None** **Unbearable**

   a. ***Indicate the average intensity of your symptoms*** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

   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 bit 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

   a. ***What treatment did you receive and when?*** _____

   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:***_____

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 ③ Medical Doctor ⑤ Other ② Chiropractor ④ Physical Therapist

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

    _____

    a. ***If you are not retired, a homemaker, or a student, what is your current work status?*** ① Full-time ③ Self –employed ⑤ Off Work ② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ ***Date*** _____

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

11. Have you or any immediate family members ever been told you have.....(please circle your answer)

	Self	Family
Cancer?	Yes.....No	Yes.....No
Diabetes?	Yes.....No	Yes.....No
High Blood Pressure?	Yes.....No	Yes.....No
Heart Disease?	Yes.....No	Yes.....No
Angina/ chest pain?	Yes.....No	Yes.....No
Stroke?	Yes.....No	Yes.....No
Osteoporosis?	Yes.....No	Yes.....No
Osteoarthritis?	Yes.....No	Yes.....No
Rheumatoid Arthritis?	Yes.....No	Yes.....No

12. In the past 3 months have you had or do you experience: (please circle your answer)

A change in your health?	Yes.....No
Nausea/Vomiting?	Yes.....No
Fever/chills/sweats?	Yes.....No
Unexplained weight **Change**?	Yes.....No
Numbness or tingling?	Yes.....No
Change in appetite?	Yes.....No
Difficulty swallowing?	Yes.....No
Changes in bowel or bladder function?	Yes.....No
Shortness of Breath?	Yes.....No
Dizziness?	Yes.....No
Upper Respiratory Infection?	Yes.....No
Urinary Tract Infection?	Yes.....No
Pregnancy?	Yes.....No

13. Do you have a history of: (please circle your answer)

Allergy/Asthma?	Yes.....No
Headaches?	Yes.....No
Bronchitis?	Yes.....No
Kidney disease?	Yes.....No
Rheumatic Fever?	Yes.....No
Ulcers?	Yes.....No
Sexually transmitted disease?	Yes.....No
Seizures?	Yes.....No

14. Do you have any other conditions not listed? YES / NO ***If YES, please list them:*** _____

15. How are you able to sleep at night? ***(check one)*** _____

[ ] Fine [ ] Moderate difficulty [ ] Only with medication

16. Do you have a problem with..... (check all that apply)

[ ] Hearing [ ] Speech [ ] Vision [ ] Communication

17. Date of last physical examination _____

18. List medications currently using:

Name	Dosage	Frequency	Route of Administration