Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

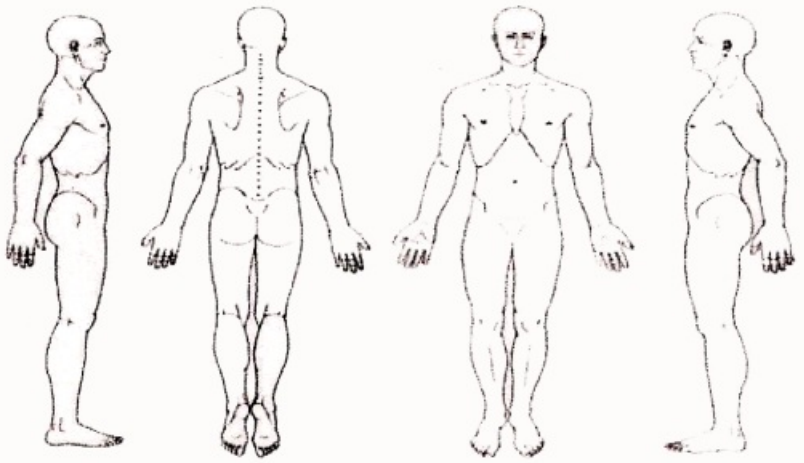
a. When did your symptoms start? _____

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 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 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 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 ⑨ 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 Health Questionnaire - page 2

ChiroCare Use Only

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuo

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ]
Feet inches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke			
O	O	Low Back Pain	O	O	Angina	O	O	Smoking/Use Tobacc
						O	O	Drug/Alcohol Depend
O	O	Shoulder Pain	O	O	Kidney Stones			
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Depression
O	O	Hand Pain	O	O	Painful Urination	O	O	Systemic Lupus
			O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip/Upper Leg Pain	O	O	Prostate Problems	O	O	Dermatitis/Eczema/R
O	O	Knee/Lower Leg Pain				O	O	HIV/AIDS
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss			
			O	O	Loss of Appetite	*Females Only*		
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Birth Control Pills
			O	O	Ulcer	O	O	Hormonal Replaceme
O	O	Joint Swelling/Stiffness	O	O	Hepatitis	O	O	Pregnancy
O	O	Arthritis	O	O	Liver/Gall Bladder Disorder	O	O	
O	O	Rheumatoid Arthritis						
			O	O	Cancer	*Other Health Problems/Issue*		
O	O	General Fatigue	O	O	Tumor	O	O	
O	O	Muscular Incoordination				O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date**