Patient Health Questionnaire - PHQ

ACH Group, Inc - From PHq-202

ACH Group Use Only rev 9/11/2002

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?

- ☐ Constantly (76 - 100% of the day)
- ☐ Frequently (51 - 75% of the day)
- ☐ Occasionally (26 - 50% of the day)
- ☐ Intermittently (0 - 25% of the day)

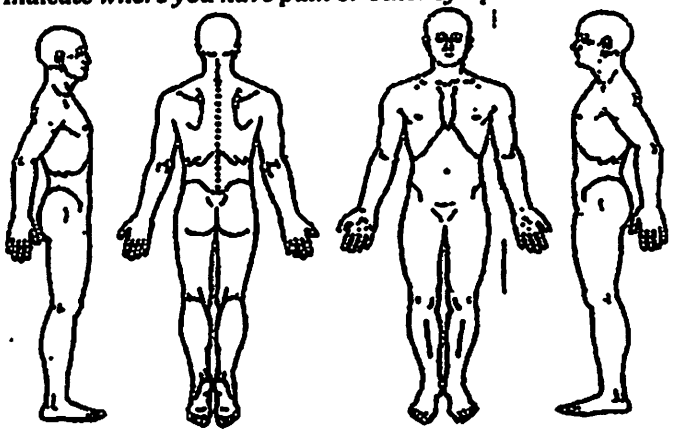
3. What describes the nature of your symptoms

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

Indicate where you have pain or other symptoms



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 ☐1

b. How much has pain interfered with your normal work (including both work outside the home and housework)

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐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)

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time

7. In general would you say your overall health right now is...

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

8. Who have you seen for your symptoms?

☐No One ☐Medical Doctor ☐Other

☐Chiropractor ☐Physical Therapist

b. What treament did you receive and when?

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

☐Xrays *date:* ☐CT Scan *date:*

☐MRI *date:* ☐Other *date:*

9. Have you had similar symptoms in the past? ☐Yes ☐No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐Xrays *date:* ☐CT Scan *date:*

☐MRI *date:* ☐Other *date:*

10. What is your occupation

☐Professional/Executive ☐Laborer ☐Retired

☐FT Student ☐Homemaker ☐Other

☐Tradesperson ☐White Collar/Secretarial

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

☐Full-time ☐Self-employed ☐Off Work

☐Part-time ☐Unemployed ☐Other

Patient Signature _____ ***Date*** _____

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Patient Name ***Date***

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? Height ____ ____ Weight ____ ____ ____ lbs

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

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

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐____

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

Doctor's Signature ***Date***