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 _____

_____

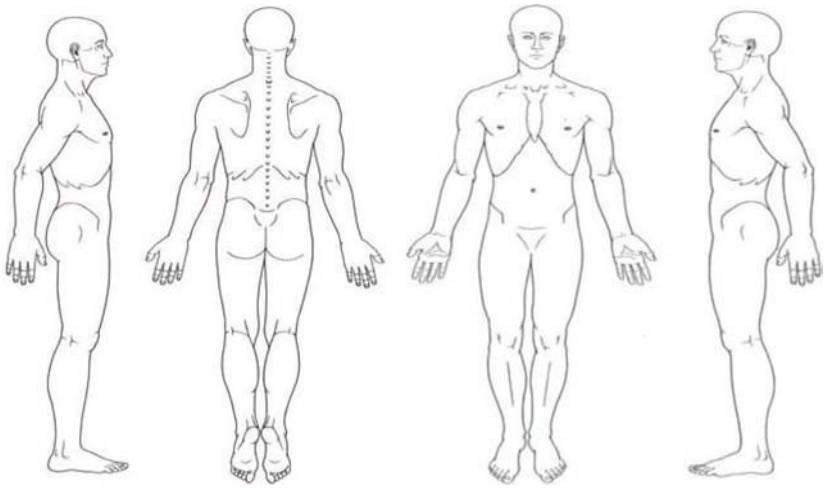
a. When did your symptoms start? _____

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
(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** _____

PATIENT INTAKE FORM (Page 2)

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?
_____

13. What concerns you the most about your problem; what does it prevent you from doing?
_____

14. What alleviates your problem?
_____

15. What is your: **Height**_____ **Weight** _____ **Age** _____ **DOB** _____

16. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

18 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	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Visual Disturbances
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dizziness
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Asthma
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Chronic Sinusitis
□	□ Arthritis	□	□ Hepatitis	**For Females Only**	
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Other:_____				

19. List all prescription medications you are currently taking:
_____

20. List all of the over-the-counter medications you are currently taking:
_____

21. List all surgical procedures you have had:
_____

22. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

23. What activities do you do outside of work?
_____

24. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

25. Have you had significant past trauma? □ No □ Yes

26. Anything else pertinent to your visit today? _____

Doctors Signature _____ ***Date*** _____