

# 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?

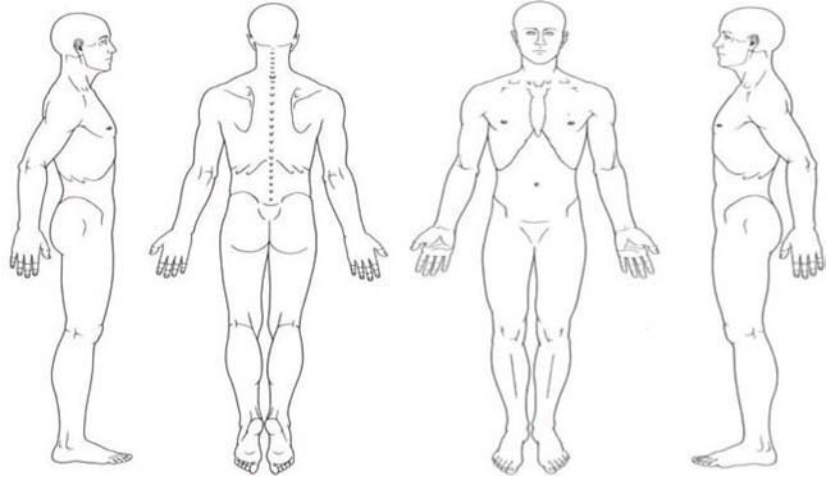
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other 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)



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan 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 Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

What is your height and weight? Height [ ] [ ] [ ] Feet [ ] [ ] [ ] Inches Weight [ ] [ ] [ ] lbs.

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
Shoulder Pain Kidney Stones Smoking/Use Tobacco Products
Elbow/Upper Arm Pain Kidney Disorders Drug/Alcohol Dependence
Wrist Pain Bladder Infection Allergies
Hand Pain Painful Urination Depression
Hip/Upper Leg Pain Loss of Bladder Control Systemic Lupus
Knee/Lower Leg Pain Prostate Problems Epilepsy
Ankle/Foot Pain Abnormal Weight Gain/Loss Dermatitis/Eczema/Rash
Jaw Pain Loss of Appetite HIV/AIDS
Joint Swelling/Stiffness Abdominal Pain
Arthritis Ulcer
Rheumatoid Arthritis Hepatitis
General Fatigue Cancer
Muscular Incoordination Tumor
Visual Disturbances Asthma
Dizziness Chronic Sinusitis

- Females Only
Birth Control Pills
Hormonal Replacement
Pregnancy

- Other Health Problems/Issues

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

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_