Patient Health Questionnaire -PHQ

Patient Name _____ Date of birth _____

When did your symptoms start? ___/___/___ Date of Surgury _____ (if applicable)

1 What are you being seen for? _____

2 How did your symptoms start? _____

3 How often do you experience your symptoms?

☐ Constantly (76%-100% of the day) ☐ Occasionally (26%-50% of the day)

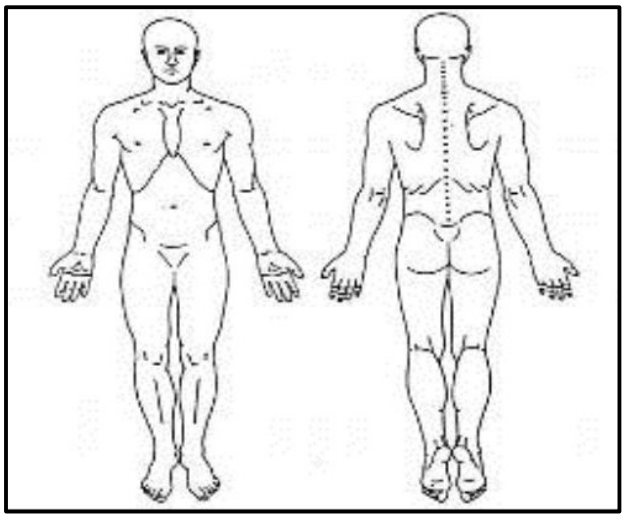
☐ Frequently (51%-75% of the day) ☐ Intermittently (0%-25% of the day)

4 Describe the nature of your symptoms.
Check all that apply.

☐ Sharp ☐ Shooting

☐ Dull Ache ☐ Burning

☐ Numb ☐ Tingling



5 How are your symptoms changing?
Check ONE below

☐ Getting better

☐ Not changing

☐ Getting worse

6 How much has it interfered with your normal work and daily activities?

☐ None of the time ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7 Indicate the intensity of pain with movement

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbareable

8 In general would you say your overall health right now is

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

9 Who have you seen for your symptoms?

☐ No One ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

What treatment did you receive and when? _____

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

☐ X-ray Date _____ ☐ CT Scan Date _____

☐ MRI Date _____ ☐ Other Date _____

11 What is your occupation? ☐ Professional/Executive ☐ Laborer ☐ Retired

☐ White Collar/Secretarial ☐ Homemaker ☐ Tradesperson

☐ Full Time Student ☐ Other _____