PATIENT HEALTH QUESTIONNAIRE – PHQ
(All Questions Must Be Answered)

Patient Name _____ **Date** _____

1. **Describe your symptoms:** _____

_____

2. **When did your symptoms start?** __/__/____ _____

3. **How did your symptoms begin** _____

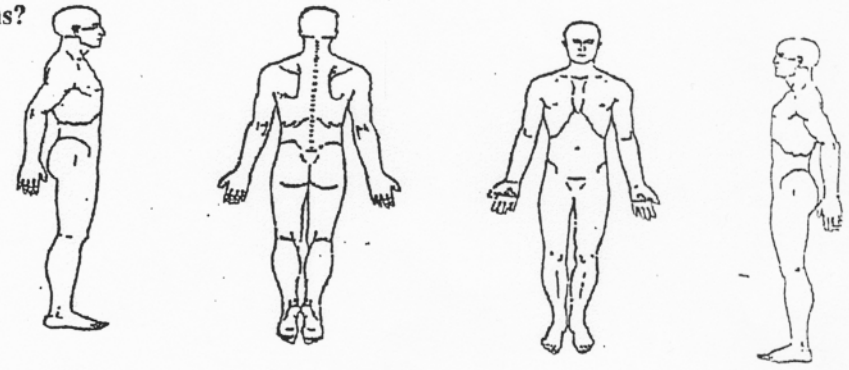
_____

4. **What is your goal for therapy?** _____

_____

5. **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)

MARK PICTURE WHERE YOU HAVE PAIN



6. **What describes the nature of your symptoms?**
   (check all that apply)
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

7. **How are your symptoms changing?**
   ① Getting Better
   ② Not Changing
   ③ Getting Worse

8. **Your symptoms are worse in:**
   ① morning ④ increased during the day
   ② afternoon ③ night ⑤ same all day

9. **What movement causes the pain to increase:** _____

During the past 4 weeks:

a. Indicate the intensity of pain at rest: **No Pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Unbearable Pain**

b. Indicate the intensity of pain with movement: **No Pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Unbearable Pain**

10. **How much has it interfered with your normal work (including home and housework)**
    ①None of the time ②A little bit ③Moderately ④Quite a bit ⑤Extremely

11. **What makes your problem better?** _____
    ①Nothing ②Lying Down ③Standing ④Sitting ⑤Movement/Exercise ⑥Inactivity

    a. What makes your problem worse? _____
    ①Nothing ②Lying Down ③Standing ④Sitting ⑤Movement/Exercise ⑥Inactivity

12. **During the past 4 weeks how much of the time has your condition interfered with your social activities?**
    (visiting with friends, relatives, etc.)
    ①All the time ②Most of the time ③Some of the time ④A little of the time ⑤None of the time

13. **In general would you say your overall health right now is...**
    ①Excellent ②Very Good ③Good ④Fair ⑤Poor

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13. Who have you seen for your symptoms? ①No One ②Medical Doctor ③Chiropractor ④Physical Therapist ⑤Other _____

a. What treatment did you receive and when? _____

14. What tests have you had for your symptoms and when were they performed? ①X-rays date:_____ ②MRI date:_____ ③CT Scan date:_____ ④Other date:_____

a. Did you have surgery? ☐ Yes ☐ No Date of Surgery if applicable: ___/___/___

15. 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? ①No One ②Medical Doctor ③Chiropractor ④Physical Therapist ⑤Other _____

16. What is your occupation? _____ ①Professional/Executive ②White Collar/Secretarial ③Tradesperson ④Laborer ⑤Homemaker ⑥FT Student ⑦Retired ⑧Other

a. If you are not retired, a homemaker, or a student, what is your current work status? ①FT ②PT ③Self-Employed ④Unemployed ⑤Off Work ⑥Other

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High blood pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	HIV / AIDS (042)
☐	☐	Cancer (199.1) Location: _____ date:__/__/__
☐	☐	Tumor (229.9)
☐	☐	Systemic Lupus (710.0)
☐	☐	Hepatitis (573.3)
☐	☐	Epilepsy (349.5)
☐	☐	Diabetes (250.0)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Arthritis (716.9)
☐	☐	Pregnancy
☐	☐	Other_____
☐	☐	Tobacco (305.1) packs/day ____
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeine drinks: cups/cans per day____

Do you have a permanent disability rating?

☐ YES ☐ NO

Location _____

_____

Date rating received __/__/____

Rating Percentage _____%

Hospitalization/Surgical Procedures (list if not described elsewhere): _____

_____

_____

_____

Medications: _____

_____

_____

_____

Present: Weight _____

Height: Feet _____ Inches _____

Patient Name _____ **Date** _____