

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

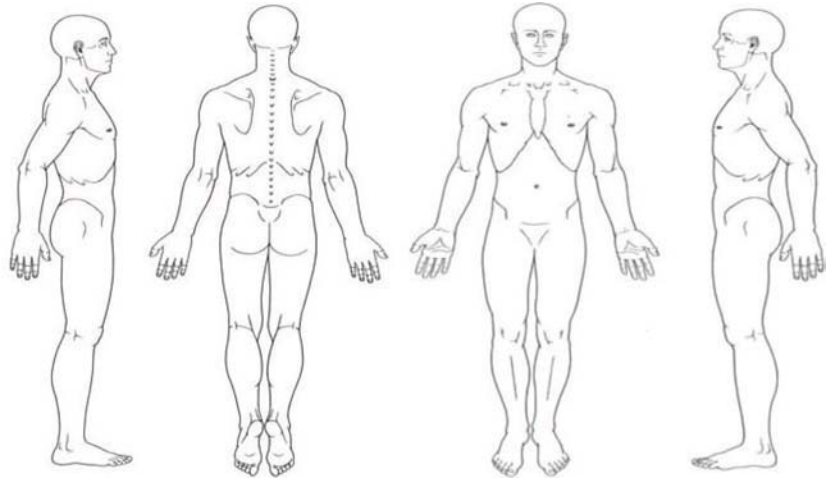
1. Describe your symptoms

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 _____

11. Have you completed an advance directive/ Do not Resuscitate Order (DNR)? A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. Yes No

12. Did anyone other than your doctor recommend our clinic ?

13. Have you had any major life changes during past year? Yes No
(e.g., new baby, job change, death of a family member)

14. SOCIAL/HEALTH HABITS

a. Smoking: Do you currently smoke tobacco? Yes No

b. Alcohol: How many drinks do you have on an average day? _____

c. Exercise: Do you exercise beyond normal daily activities and chores?

(a) Yes: Describe the exercise: _____
How often do you exercise or do physical activity? _____

(b) No

15. FAMILY HISTORY (circle appropriate response)

- a. Heart disease: yes/ no e. Cancer: yes/ no b. Hypertension: yes/ no
f. Psychological: yes/ no c. Stroke: yes/ no g. Arthritis: yes/ no
d. Diabetes: yes/ no h. Osteoporosis/ Osteopenia: yes/no

16. MEDICAL/SURGICAL HISTORY

a. Please check if you have / ever had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation/vascular | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Repeated infections | <input type="checkbox"/> Ulcers/stomach | <input type="checkbox"/> Low blood sugar/ hypoglycemia | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Infectious disease. (e.g., tuberculosis, hepatitis) | |
| <input type="checkbox"/> Developmental or Growth Problems | | <input type="checkbox"/> High blood sugar problems /Diabetes | |
| <input type="checkbox"/> Other: _____ | | | |

b. Have you had any of these symptoms within the last 6 months? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Changes with Bowels or Urinary Problems |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Unexplained weight loss / gain |
| <input type="checkbox"/> Unexplained weakness in arms or legs | <input type="checkbox"/> Fever / chills / sweats |
| <input type="checkbox"/> Calf pain or swelling | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Loss or changes in sensation | |
| <input type="checkbox"/> Radicular pain (Numbness, tingling, shooting pain in (L) arm, (R) arm, (L) leg or (R) leg) | |
| <input type="checkbox"/> Other: _____ | |

c. Have you ever had surgery? Yes No If yes, please describe and include dates:

	Month	Year		Month	Year
_____	/		_____	/	
_____	/		_____	/	

- For women only:** Vaginal or C-section delivery? Yes No
Are you pregnant, or think you might be pregnant? Yes No
Do you have other gynecological or obstetrical difficulties? Yes No

17. MEDICATIONS Do you take any medications? Yes No

If yes, please list: _____

18. What are your functional goals for physical therapy (be able to do that you are not doing now)? _____

