# Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

***Patient Name*** _____ ***Date*** _____

***1. Describe your symptoms*** _____

_____

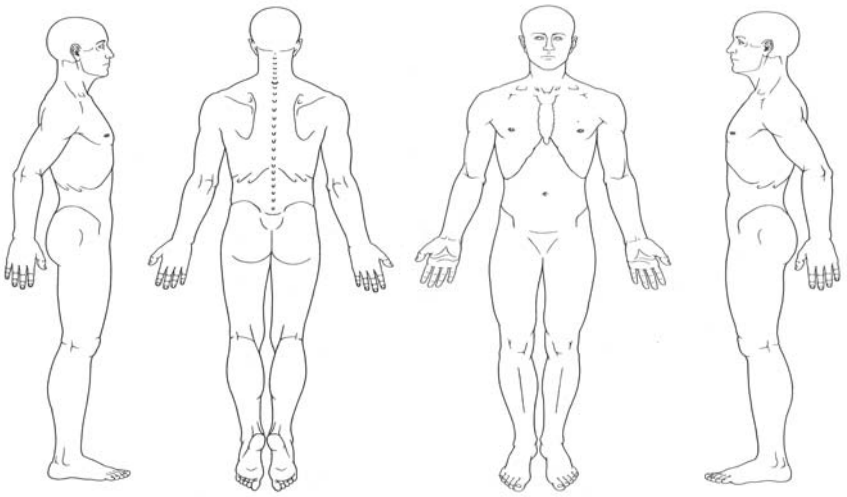
*a. When did your symptoms start?* _____

*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 <u>past 4 weeks:</u>***

*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 <u>past 4 weeks</u> 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

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***8. Who have you seen for your symptoms?***

① No One
② Other 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 Other 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 | ○ | ○ | Smoking/Use Tobacco Products |
| | | | | | | ○ | ○ | Drug/Alcohol Dependence |
| ○ | ○ | Shoulder Pain | ○ | ○ | Kidney Stones | | | |
| ○ | ○ | Elbow/Upper Arm Pain | ○ | ○ | Kidney Disorders | ○ | ○ | Allergies |
| ○ | ○ | Wrist Pain | ○ | ○ | Bladder Infection | ○ | ○ | Depression |
| ○ | ○ | Hand Pain | ○ | ○ | Painful Urination | ○ | ○ | Systemic Lupus |
| | | | ○ | ○ | Loss of Bladder Control | ○ | ○ | Epilepsy |
| ○ | ○ | Hip/Upper Leg Pain | ○ | ○ | Prostate Problems | ○ | ○ | Dermatitis/Eczema/Rash |
| ○ | ○ | Knee/Lower Leg Pain | | | | ○ | ○ | HIV/AIDS |
| ○ | ○ | Ankle/Foot Pain | ○ | ○ | Abnormal Weight Gain/Loss | | | |
| | | | ○ | ○ | Loss of Appetite | ***Females Only*** | | |
| ○ | ○ | Jaw Pain | ○ | ○ | Abdominal Pain | ○ | ○ | Birth Control Pills |
| | | | | | | ○ | ○ | Hormonal Replacement |
| ○ | ○ | Joint Swelling/Stiffness | ○ | ○ | Ulcer | ○ | ○ | Pregnancy |
| ○ | ○ | Arthritis | ○ | ○ | Hepatitis | ○ | ○ | |
| ○ | ○ | Rheumatoid Arthritis | ○ | ○ | Liver/Gall Bladder Disorder | | | |
| | | | | | | ***Other Health Problems/Issues*** | | |
| ○ | ○ | General Fatigue | ○ | ○ | Cancer | | | |
| ○ | ○ | Muscular Incoordination | ○ | ○ | Tumor | ○ | ○ | |
| ○ | ○ | Visual Disturbances | | | | ○ | ○ | |
| ○ | ○ | Dizziness | ○ | ○ | Asthma | ○ | ○ | |
| | | | ○ | ○ | Chronic Sinusitis | | | |

***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** _____