Patient Health Questionnaire - PHQ

ACN Group of California - Form PHQ-202

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

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

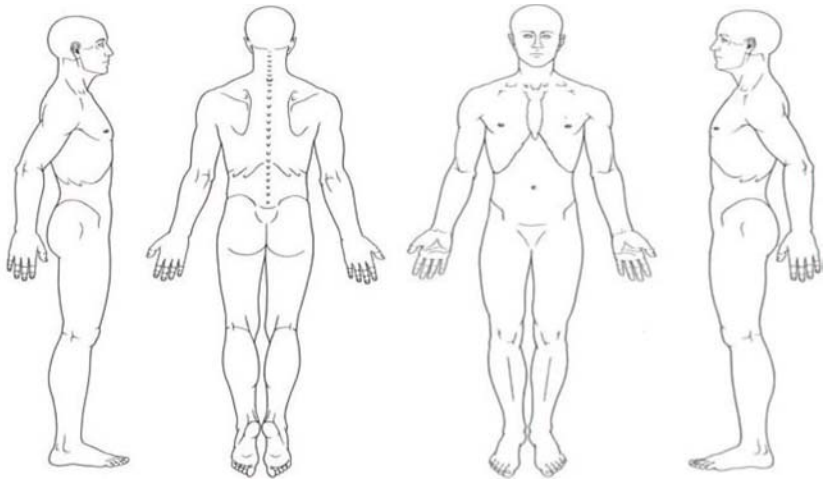
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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 past 4 weeks:

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 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:* _____ 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 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 then 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:**

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

☐ Other: _____ _____

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

☐ Chest Pains	☐ Changes with Bowels or Urinary Problems
☐ Dizziness or blackouts	☐ Unexplained weight loss / gain
☐ Unexplained weakness in arms or legs	☐ Fever / chills / sweats
☐ Calf pain or swelling	☐ Pain at night
☐ Loss or changes in sensation	

☐ Radicular pain (Numbness, tingling, shooting pain in (L) arm, (R) arm, (L) leg or (R) leg)

☐ 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)? _____

_____

_____