

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

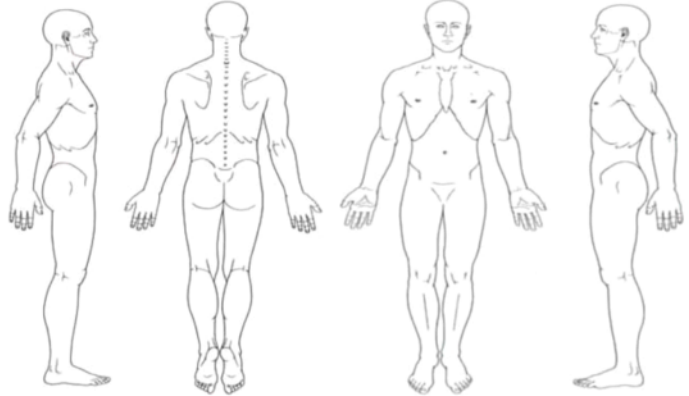
a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms?

- (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
- (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 (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 _____

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11. Do you consider this problem to be severe?

- Yes Yes, at times No

12. What aggravates your problem?

13. What concerns you the most about your problem; what does it prevent you from doing?

14. What alleviates your problem?

15. What is your: Height _____ Weight _____ Age _____ Birth Date _____

16. What type of exercise do you do?

- Strenuous Moderate Light None

17. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

18 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
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	For Females Only	
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

19. List all prescription medications you are currently taking:

20. List all of the over-the-counter medications you are currently taking:

21. List all surgical procedures you have had:

22. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

23. What activities do you do outside of work?

24. Have you ever been hospitalized? No Yes

if yes, why _____

25. Have you had significant past trauma? No Yes

26. Anything else pertinent to your visit today? _____

Patient Signature _____ **Date:** _____