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 _____

_____

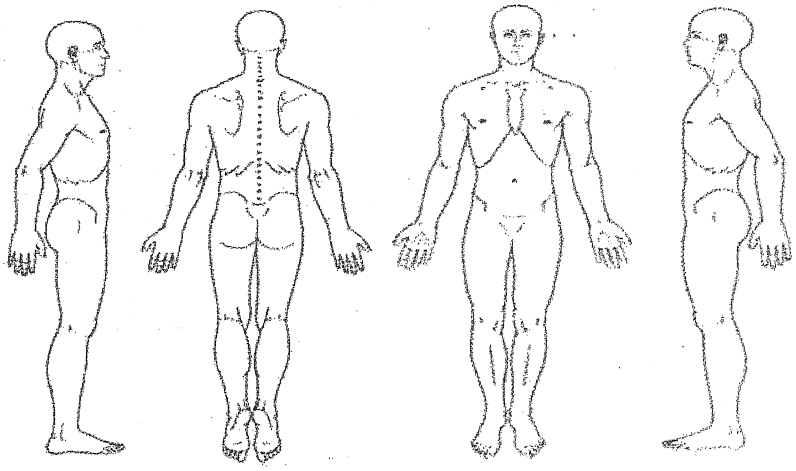
a. When did your symptoms start? _____

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 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

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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** _____

REVIEW OF SYSTEMS: Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
NECK		
Stiff Neck	☐	☐
Soreness	☐	☐
HEART		
Cold Extremities	☐	☐
GASTROINTESTINAL		
Abdominal Pain	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Jaw Pain	☐	☐

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐
Ringing	☐	☐

MEDICAL HISTORY	
AIDS/HIV	☐
Alcoholism	☐
Allergy Shots	☐
Anemia	☐
Anorexia	☐
Arthritis	☐
Asthma	☐
Bleeding Disorders	☐
Bronchitis	☐
Cancer	☐
Cataracts	☐
Chemical Dependency	☐
Depression	☐
Diabetes	☐
Emphysema	☐
Epilepsy	☐
Fractures	☐
Glaucoma	☐
Gout	☐
Heart Disease	☐
Hepatitis	☐
Hernia	☐
Herniated Disc	☐
High Cholesterol	☐

MEDICAL HISTORY cont'd	
Kidney Disease	☐
Liver Disease	☐
Measles	☐
Migraines	☐
Miscarriage	☐
Mononucleosis	☐
Multiple Sclerosis	☐
Mumps	☐
Osteoporosis	☐
Pacemaker	☐
Parkinson's Disease	☐
Pinched Nerve	☐
Pneumonia	☐
Polio	☐
Prostate	☐
Prosthesis	☐
Rheumatoid Arthritis	☐
Stroke	☐
Thyroid	☐
Tuberculosis	☐
Tumors, Growths	☐
Typhoid Fever	☐
Ulcers	☐
Whooping Cough	☐

Other_____

_____

_____

NAME _____

Referred by:_____

Patient Name_____ Number_____ Date_____

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