

# 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?

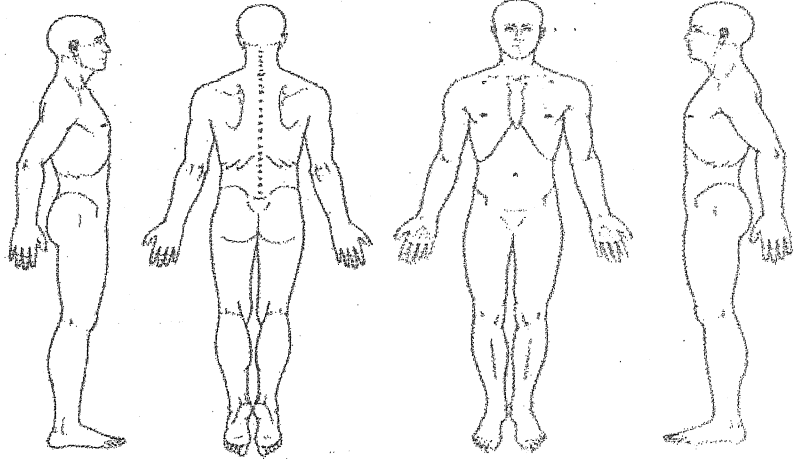
\_\_\_\_\_

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 \_\_\_\_\_

**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 \_\_\_\_\_