

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group Use Only rev 9/11/2002

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ AGE \_\_\_\_\_

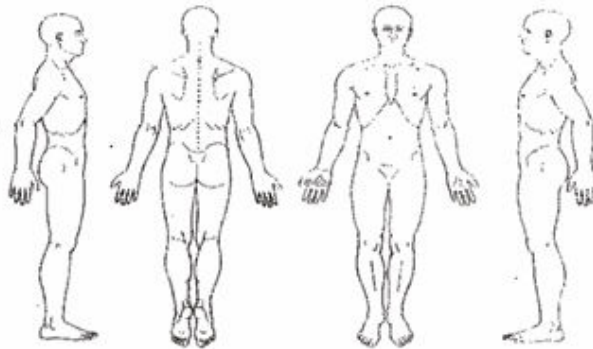
1. Describe your symptoms \_\_\_\_\_  
 \_\_\_\_\_

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 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 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: \_\_\_\_\_
- 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 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 \_\_\_\_\_

