

# 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?

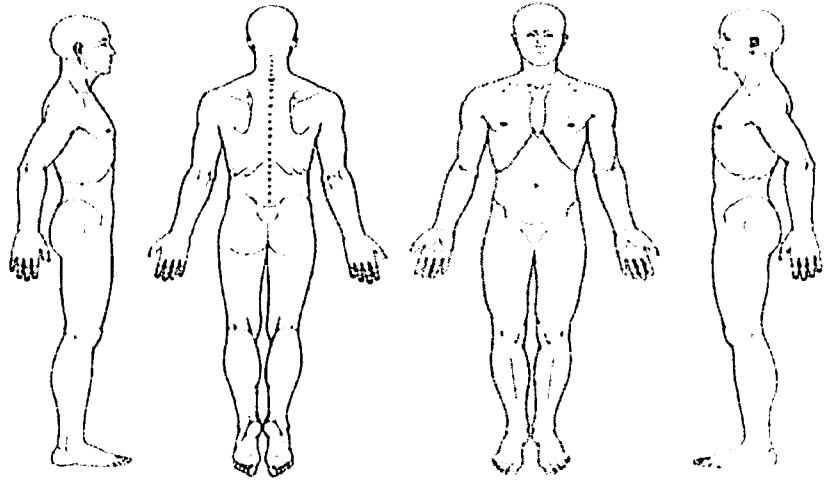
\_\_\_\_\_

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 Unbearable ⑩

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      ③ Medical Doctor      ⑤ Other  
② Chiropractor      ④ Physical Therapist

## 10. What is your occupation?

- ① Professional/Executive      ④ Laborer      ⑦ Retired  
② White Collar/Secretarial      ⑤ Homemaker      ⑧ Other  
③ Tradesperson      ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time      ③ Self-employed      ⑤ Off work  
② Part-time      ④ Unemployed      ⑥ Other

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**11. Have you or any immediate family members ever been told you have.... (please circle your answer)**

	<b>Self</b>	<b>Family</b>
Cancer?	Yes.....No	Yes.....No
Diabetes?	Yes.....No	Yes.....No
High Blood Pressure?	Yes.....No	Yes.....No
Heart Disease?	Yes.....No	Yes.....No
Angina/chest pain?	Yes.....No	Yes.....No
Stroke?	Yes.....No	Yes.....No
Osteoporosis?	Yes.....No	Yes.....No
Osteoarthritis?	Yes.....No	Yes.....No
Rheumatoid Arthritis?	Yes.....No	Yes.....No

**12. In the Past 3 months have you had or do you experience: (please circle your answer)**

A change in your health?	Yes.....No
Nausea/vomiting?	Yes.....No
Fever/chills/sweats?	Yes.....No
Unexplained weight change?	Yes.....No
Numbness or tingling?	Yes.....No
Changes in appetite?	Yes.....No
Difficulty swallowing?	Yes.....No
Changes in bowel or bladder function?	Yes.....No
Shortness of breath?	Yes.....No
Dizziness?	Yes.....No
Upper Respiratory Infection?	Yes.....No
Urinary Tract Infection?	Yes.....No
Pregnancy?	Yes.....No

**13. Do you have a history of: (please circle your answer)**

Allergies/Asthma?	Yes.....No
Headaches?	Yes.....No
Bronchitis?	Yes.....No
Kidney disease?	Yes.....No
Rheumatic Fever?	Yes.....No
Ulcers?	Yes.....No
Sexually transmitted disease?	Yes.....No
Seizures?	Yes.....No

**14. How are you able to sleep at night? (check one)**

Fine       Moderate difficulty       Only with medication

**15. Do you have a problem with..... (check all that apply)**

Hearing       Speech       Vision       Communication

**16. Date of last physical examination \_\_\_\_\_**

**17. List medications currently using:**

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**18. List ALL surgeries you have had, and include date of each:**

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