Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

1. Describe your symptoms _____

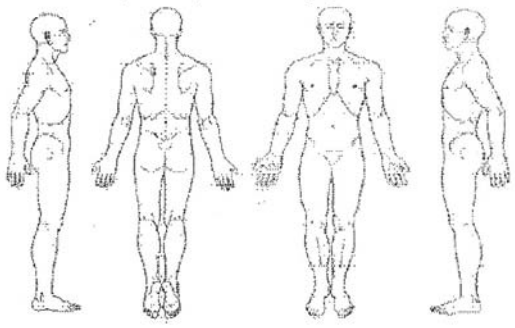
_____

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

8. Who have you seen for your symptoms?
① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

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 Other 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 _____

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American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

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

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____