For Office Use Only

Dx: _____

Patient Health Questionnaire

Patient Name _____ **Age** _____ **Weight** _____ **Height** _____

Occupation: _____

1. Do you have or have you ever had any of the following? (Please check all that apply)

☐Allergies ☐Diabetes ☐Heart problems ☐Liver problems ☐Rheumatoid arthritis

☐Arthritis ☐Fibromyalgia ☐High blood pressure ☐Osteoporosis ☐Thyroid problems

☐Cancer ☐Gout ☐Kidney problems ☐Parkinson's Disease ☐Tuberculosis

☐Stroke ☐Ulcers/stomach problems ☐Other: _____

Past Surgeries: _____

2. Have you recently had/have: (please check all that apply)

☐Breathing difficulty ☐Change in bowel or bladder function ☐Fatigue/lethargy ☐Night Pain

☐Loss of balance or falling ☐Fever/chills/sweats ☐Nausea/vomiting ☐ Dizziness/ringing in ears

☐Severe headaches ☐ Unexplained weight loss ☐Rash

3. Have you had similar symptoms for what you are being treated today? ☐ Yes ☐ No

If yes, who do you see? ☐ This Office ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other

4. Describe your symptoms: _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

5. How often do you experience your symptoms?

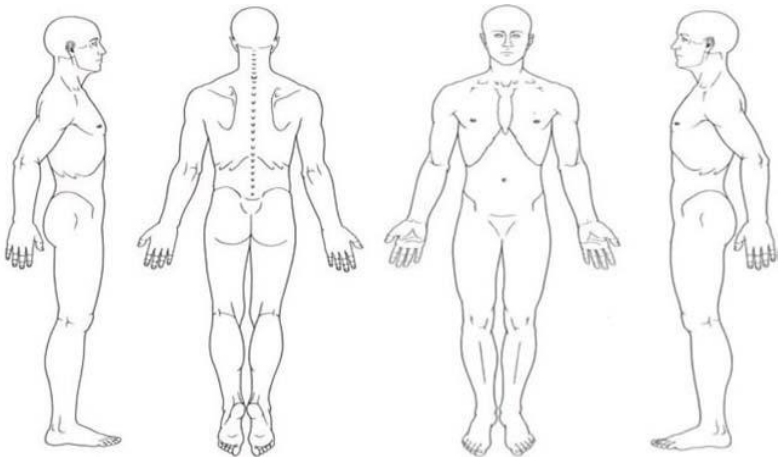
☐ Constantly (76-100% of the day)

☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day)

☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



6. What describes the nature of your symptoms?

☐ Sharp ☐ Shooting

☐ Dull Ache ☐ Burning

☐ Numb ☐ Tingling

7. How are your symptoms changing since it started?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

8. Average pain intensity:

0 = No Pain
5 = Moderate
10 = Extreme

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

9. How much has pain interfered with your normal work/activities (*both outside the home, and housework*)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

10. What tests have you had for your symptoms and when were they performed?

☐ X-Rays Date:_____ ☐ MRI Date: _____ ☐ CT Scan Date: _____ ☐ Other:_____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient/Guardian Signature: _____ _____ **Date:** _____