Patient Health Questionnaire – PHQ

Patient Name______________________________________ Date__________________

1. Describe your symptoms: ______________________________________

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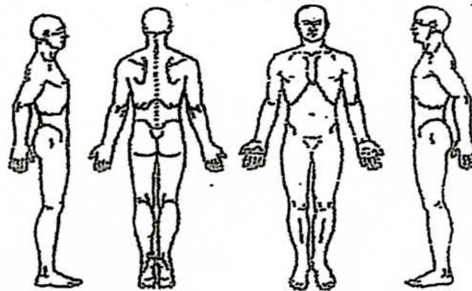
2. When did your symptoms start? ______________________________________

3. What caused your symptoms? ______________________________________

4. How often do you experience your symptoms? (A) Morning worse (B) Evening worse
   (1) 76-100% of the day (2) 51-75% of the day (3) 26-50% of the day (4) 0-25% of the day

Mark where you have symptoms



5. Describe your symptoms:
   (1) Sharp (2) Dull ache (3) Numb (4) Shooting
   (5) Burning (6) Tingling (7) Stiffness (8) Sore

6. How are your symptoms changing?
   (1) Getting Better (2) Same (3) Getting Worse

7. Since the start of your condition:

   a. Indicate the average intensity of your symptoms:(none) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
   b. How much has pain interfered with your work life? (Include work outside/ inside home)
   (1) Not at All (2) A Little Bit (3) Moderately (4) Quite a Bit (5) Extremely

8. How often has your condition interfered with your social life?
   (1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None

9. In general describe your overall health right now is....
   (1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

10. Who have you seen for your condition?
    (1) No One (2) Chiropractic Doctor (3) Medical Doctor (4) Physical Therapist (5) Other
    a. Treatment received: ______________________________ Date ____________
    b. Diagnostic Tests: (1) x-rays-date_______ (2) MRI-date ________ (3) Other-date _______

11. Have you had similar symptoms in the past? (1) Yes (2) No
    a. If you have received previous treatment for similar symptoms, who did you see?
    (1) This Office (2) Chiropractic Doctor (3) Medical Doctor (4) Physical Therapist (5) Other

12. List all surgeries and dates: ______________________________________

Patient Signature: ______________________________ **Date:** ____________