Patient Health Questionnaire – PHQ

Patient Name ___________________________________ *Today's Date* _________________________________

1. ***Describe your symptoms***____

   ____

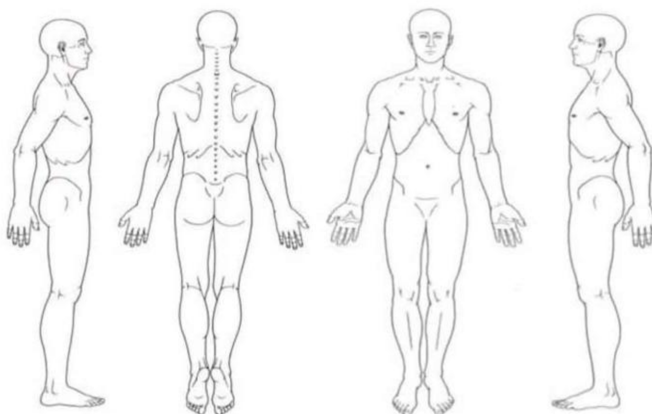
   When did you symptoms start? ____

   ____

   How did you 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
   - 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. ***Indicate the intensity of your symptoms in the past 48 hours:***

	None										*Unbearable*
At Best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
At Worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. ***How much has pain interfered with your normal daily home activities and work outside of the home?***

   ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

7. ***Who have you seen for your symptoms:*** (check all that apply)

   ① Medical doctor ② pain specialist ③ surgeon ④ chiropractor ⑤ physical therapist

8. ***What tests have you had and when were they performed?***
   - ① Xrays *date* ___________ ③ CT Scan *date* ___________
   - ② MRI *date* ___________ ④ Other *date* ___________

9. ***What is your occupation?***

   ____

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

10. ***If you are not retired, a homemaker, or a student, what is your current work status?***
    - ① Full-time
    - ② Part-time
    - ④ Self-employed
    - ⑤ Unemployed
    - ⑦ Off work
    - ⑧ Other

Patient Signature ______________________________________ Date _____________________________________

(Turn over to other side)

11. Do you have any of the Following? (please circle your answer)

Hepatitis?	Yes……No	Osteoporosis?	Yes……No
Pacemaker?	Yes……No	Osteoarthritis?	Yes……No
Stroke?	Yes……No	Rheumatoid Arthritis?	Yes……No
Diabetes?	Yes……No	High Cholesterol?	Yes……No
High Blood Pressure?	Yes……No	HIV?	Yes……No
Heart Disease?	Yes……No	Gastrointestinal Problems?	Yes……No
Angina/chest pain?	Yes……No	Hernias?	Yes……No
Cancer? Location______________?	Yes……No	Joint Replacements	Yes……No
Spinal Surgeries?	Yes……No	Other Major Surgeries?	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	Changes in bowel or bladder function?	Yes……No
Nausea/Vomiting?	Yes……No	Shortness of breath?	Yes……No
Fever/ Chills / Sweats?	Yes……No	Dizziness?	Yes……No
Unexplained weight change?	Yes……No	Upper Respiratory infection?	Yes……No
Numbness or tingling?	Yes……No	Pregnancy?	Yes……No
Changes in appetite?	Yes……No	Unusual weakness?	Yes……No
Difficulty swallowing?	Yes……No	Unusual fatigue?	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	
Incontinence?	Yes……No	
Orthopedic Surgeries?	Yes……No	What kind? ____

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: □ ***See Provided List***

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