Patient Health Questionnaire – Page 1

1.) Describe your symptoms and how they began: _____

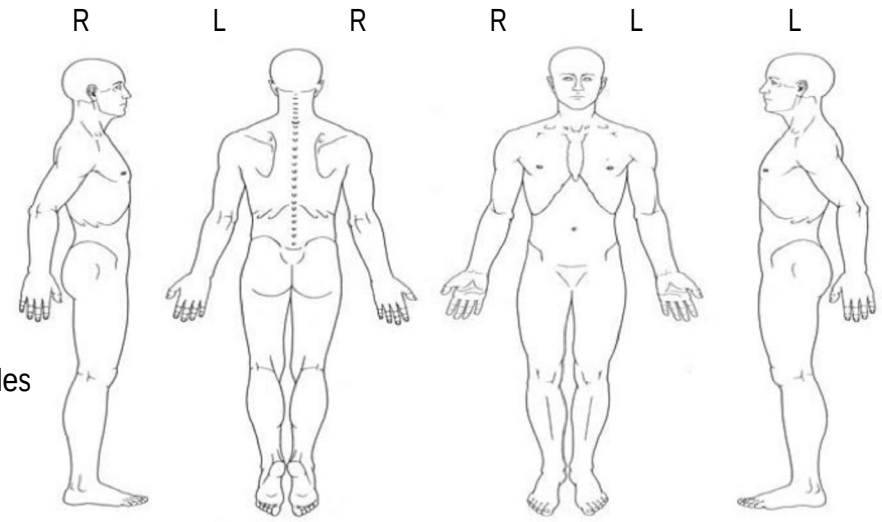
_____

_____

2.) 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)

3.) Draw where you have pain or other symptom.



4.) Describe your symptoms.

☐ Sharp ☐ Dull ☐ Ache ☐ Sore
☐ Numb ☐ Burning ☐ Tingling
☐ Shooting ☐ Stabbing ☐ Pins/Needles

5.) How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

6.) How bad are your symptoms at their:

QVAS: _____

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

7.) How do your symptoms affect your ability to perform daily activities?

_____

8.) What makes your symptoms worse: _____

9.) What makes your symptoms better: _____

10.) Have you had similar symptoms in the past? ☐ Yes ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ Medical Doctor ☐ Physical Therapist
☐ Chiropractor ☐ Other: _____

11.) What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

12.) What is your Occupation? _____

What is your current work status? ☐ Full Time ☐ Part Time ☐ Off Work ☐ Self Employed ☐ Other _____

Patient Name:_____

Patient Signature: _____ ***Date:***_____

Patient Health Questionnaire – Page 2

For each of the conditions listed below, place a check in the Past column in 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*	
☐	☐	Headache/Migraine	☐	☐	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/Tobacco Use
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Anxiety
☐	☐	Wrist/Forearm Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Thigh Pain	☐	☐	Mouth/Tooth Pain	☐	☐	Other Nerve Disorders
☐	☐	Knee/Lower Leg Pain				☐	☐	Dermatitis/Eczema/Rash
☐	☐	Ankle/Foot Pain	☐	☐	Abdominal Weight Gain/Loss	☐	☐	HIV/AIDS
			☐	☐	Loss of Appetite	☐	☐	Cancer
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
			☐	☐	Ulcer	☐	☐	Coffee Drinker
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Acid Reflux
☐	☐	Arthritis	☐	☐	Pancreatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Irritable Bowel Syndrome	Men Only		
			☐	☐	Liver/Gall Bladder Disorder	☐	☐	Prostate Problems
☐	☐	General Fatigue	☐	☐	Constipation	☐	☐	Erectile Dysfunction
☐	☐	Muscular Incoordination	☐	☐	Diarrhea			
☐	☐	Visual Disturbances				Females Only		
☐	☐	Dizziness	☐	☐	Chronic Sinusitis	☐	☐	Birth Control
☐	☐	Thyroid Problems	☐	☐	Asthma	☐	☐	Hormonal Replacement
☐	☐	Allergies	☐	☐	Lung Disease	☐	☐	Pregnancy

List all prescription and over-the counter **medications** you are taking.

List all **nutritional/herbal supplements** you are taking.

List all **surgical** procedures, **hospitalizations, major accidents, major illnesses**.

List any diseases/conditions that an immediate **family member** has had.

Patient Signature: _____ ***Date:*** _____

Doctor Signature: _____ ***Date:*** _____