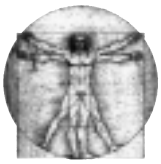
PATIENT HEALTH QUESTIONNAIRE



NAME_____ DATE____/____/____
MONTH DAY YEAR

In the space below, please describe your major complaint.
If you have an additional complaint, please describe on page 3.

1. Please Describe Your Complaint: _____

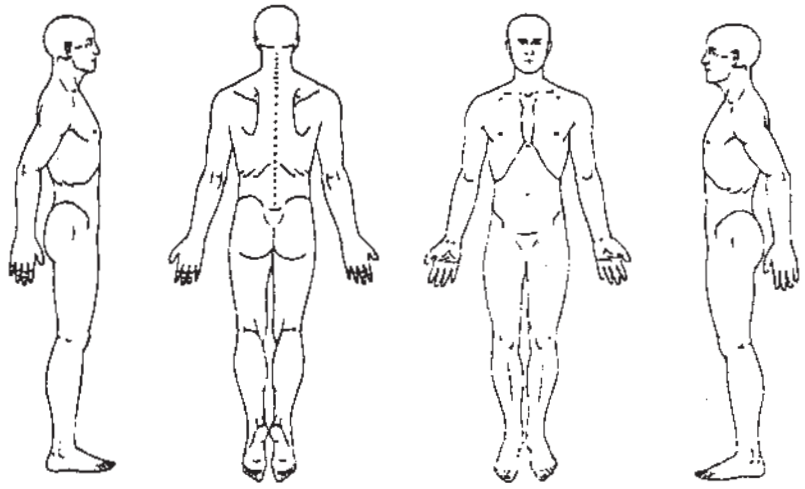
_____

_____

a. Description:
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency:
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25%or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



c. Indicate intensity of your pain at its lowest and highest level No Pain [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Unbearable Pain

d. Your symptoms are ☐ decreasing ☐ not changing ☐ increasing

e. Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day.

2. When did your problem begin: SPECIFIC DATE IF POSSIBLE? _____ Describe how your problem began: _____

_____

_____

3. Have you been treated ***for this episode***? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
Are you currently being seen? ☐ Yes ☐ No
When and what treatment? __/__/__ _____

_____

4. ***In the past*** have you been treated for the same or a similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
When and what treatment did you receive? _____

_____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other

6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other

7. How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

8. General Physical Activity: ☐ No regular exercise program ☐ Light exercise program ☐ Moderate exercise program ☐ Strenuous exercise program

9. Are your complaints affecting your ability to be active?
- ☐ No effect
- ☐ Some physical restrictions (able to perform light duty work and houshold tasks).
- ☐ Need limited assistance with common everyday tasks.
- ☐ Need assistance often.
- ☐ Have a significant inability to function without assistance.
- ☐ Am totally disabled (impaired). Cannot care for self.

10. Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion

11. Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ YES ☐ NO

12. What is your current work status?
- [1] Full time, no restrictions.
- [2] Full time, with restrictions.
- [3] Part time, no restrictions.
- [4] Part time, with restrictions.
- [5] Off work due to restrictions.
- [6] Full time homemaker.
- [7] Unemployed.
- [8] Retired.
- [9] Full time student.
- [10] Other: _____

PLEASE CONTINUE ON PAGE 2

Patient's Signature:_____ Date: __/__/____