Patient Health Questionnaire Date_____

Patient Name _____ **Address** _____

City _____ **State**_____ **Zip Code**_____ Age_____

Birth Date_____ **Gender** M F **Status:** Married Single Widowed Divorced Separated

Spousal Information (if they are insured) _____ **Birth Date**_____

Home Phone _____ **Cell**_____ **Email**_____

Employer_____ **Type of Work**_____

Health Insurance Co._____ **I.D.#**_____ **Group#**_____

Emergency Contact and Number_____ **Relationship**_____

SS#_____

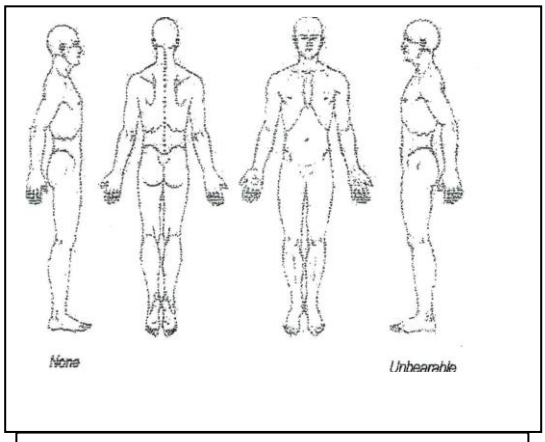
1. Describe your Current Symptoms

a. When did your symptoms start? _____

b. How did you symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



0 1 2 4 5 6 7 8 9 10

3. What describes the nature of your symptoms?

1. sharp 4.Shooting
2. Dull ache 5. Burning
3. Numb 6. Tingling

4. How are your symptoms changing?

1. Getting Better
2. Not Changing
3. Getting Worse

5. Currently:

a. Indication of the average intensity of your symptoms

b. How much has your pain interfered with your normal work (including both work outside the home & housework)

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

6. Since your pain began, how much of the time has your condtion interfered with your daily activities?

1. All of the time 2. Most of the time 3.Some of the time 4.A little of the time 5. None of the time

7. In general, would you say your overall health right now is……..

1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

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8. Who have you seen for your symptoms? 1. No One 3. Medical Doctor 5. Other_____
2. Chiropractor 4. Physical Therapist

a) What treatment did you receive and when?_____

9. Have you had similar symptoms in the past? Yes NO **(circle one)**

a. if YES, did you require treatment for a past/similar condition? Yes No Condition resolved? Yes NO

Patient Signature_____ **Date**_____