PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

***Instructions**: Please complete this form as it relates to your current episode of pain, even if the symptoms are chronic or long-standing. For example, if you were injured in an accident many years ago, but a recent flare-up (also known as an exacerbation) caused you to seek treatment again, this flare-up is the current episode.*

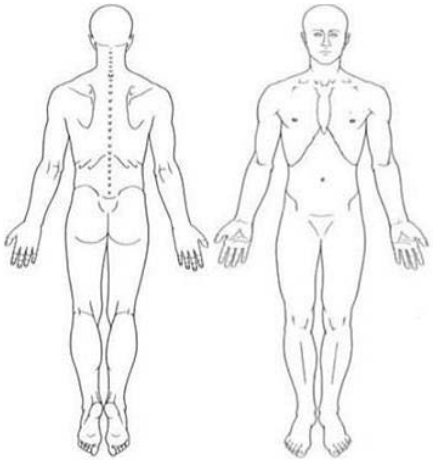
1. What is the reason for your visit today? _____

a. Approximately when did this current episode start? _____

b. What brought on this current episode? _____

c. Is this episode a worsening of a prior injury? ☐ No ☐ Yes, it was: ☐ Work-related ☐ Auto Accident ☐ Other

2. Location: Where does it hurt?



3. Nature of Symptoms:

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ _____
- ☐ _____

4. What is the intensity of your symptoms?

	None	Mild	Moderate	Severe
Currently:	⓪	① ② ③	④ ⑤ ⑥	⑦ ⑧ ⑨ ⑩
At its worst:	⓪	① ② ③	④ ⑤ ⑥	⑦ ⑧ ⑨ ⑩
At its best:	⓪	① ② ③	④ ⑤ ⑥	⑦ ⑧ ⑨ ⑩

5. How often do you experience symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (56-50% of the day)
- ☐ Intermittently (0-25% of the day)

6. What makes your symptoms worse?

_____

_____

_____

7. Other/Prior Treatment: What have you tried to relieve your symptoms?

- ☐ Chiropractic
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Acupuncture
- ☐ Massage
- ☐ _____
- ☐ Prescription Meds: _____
- ☐ Over-the-Counter Meds: _____
- ☐ Homeopathic Remedies: _____

8. Activities of Daily Living: How much does this condition interfere with your life and ability to function?

	None	Mild	Moderate	Severe
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

	None	Mild	Moderate	Severe
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving/Riding in a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Social life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐

9. What is your current work status?

- ☐ Working – Full/Normal Duty
- ☐ Working – Modified/Light Duty
- ☐ Unemployed.....last date worked: _____
- ☐ Retired.....last date worked: _____

10. What is your current occupation?

☐ Homemaker ☐ Full-Time Student ☐ Retired ☐ _____

11. Current: Height _____feet _____inches **Weight** _____pounds **Smoking Status:** _____

12. Additional Comments: _____

_____