Arch Health Partners

Patient Name: _____
DOB: _____
MRN: _____

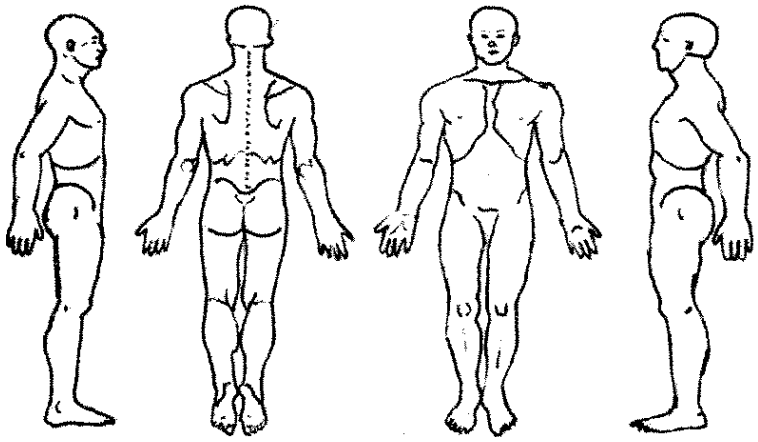
Patient Health Questionnaire – PHQ

Date _____
Your Age _____

1. **Describe your symptoms** _____
   _____

   a. When did your symptoms start? _____
   b. How did your symptoms begin? _____

2. **How often do you experience your symptoms? Indicate where you have pain or other 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. **What describes the nature of your symptoms?**
   - ☐ Sharp
   - ☐ Dull ache
   - ☐ Numb
   - ☐ Shooting
   - ☐ Burning
   - ☐ Tingling

4. **How are your symptoms changing?**
   - ☐ Getting Better
   - ☐ Not Changing
   - ☐ Getting Worse

5. **During the past 4 weeks:**
   a. Indicate the average intensity of your symptoms
   - ☐ 1 None
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ 4
   - ☐ 5
   - ☐ 6
   - ☐ 7
   - ☐ 8
   - ☐ 9
   - ☐ 10 Unbearable

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b. How much pain interfered with your normal work (including both work outside the home, and housework)
- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with social activities?
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

7. In general would you say your overall health right not is…
- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

8. Who have you seen for your symptoms?

☐ No One ☐ Medical Director ☐ Other ☐ Chiropractor ☐ Physical Therapist ☐ Other

a. What treatment did you receive and when? _____

b. What test have you had for your symptoms and when were they performed?

Xrays date: _____ CT Scan date: _____ MRI date: _____ Other date: _____

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

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

☐ This office ☐ Medical Director ☐ Chiropractor ☐ Physical Therapist ☐ Other

10. What is your occupation?

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson
☐ Laborer ☐ Homemaker ☐ FT Student ☐ Other _____

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work ☐ Part-time ☐ Unemployed
☐ Other

11. Were you hospitalized for this problem? ☐ Yes ☐ No
If yes, Dates: _____

12. Do you use a: ☐ Cane ☐ None ☐ Walker ☐ Other: _____

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13. What type of exercise are you currently doing? _____

14. Rate your stress level over the past 4 weeks: (circle)

- ☐ No Stress
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ High Stress

15. Any recent significant change in your appetite? ☐ Yes ☐ No

16. Have you in the past or are you currently experiencing any of the following??

☐ Cardiac Problems ☐ Diabetes ☐ High Blood Pressure ☐ Allergies ☐ Kidney Problems
☐ Intestinal Problems ☐ Cancer ☐ Seizures ☐ Rheumatoid Arthritis
☐ Fibromyalgia ☐ Depression ☐ Drug/Alcohol Dependency ☐ Dizzy Spells
☐ Pacemaker ☐ Circulatory Problems ☐ Vision Problems ☐ Hearing Problems
☐ Balance Problems ☐ Urination Leakage ☐ Pelvic Pain ☐ Osteoarthritis
☐ Frequent/Sudden Urges to Urinate ☐ Other: _____

17. Have you ever had a broken bone or fracture? ☐ Yes ☐ No
If yes, which body part? _____

18. Do you smoke? ☐ Yes ☐ No. If yes, # of packs per day? _____

19. Are you pregnant? ☐ Yes ☐ No

20. List any medications allergies:

_____
_____

21. List all prescriptions or over the counter medications you are currently taking:

_____
_____

22. What would you like to learn more about your illness/injury? _____

_____
_____