Arch Health Partners
Orthopedics

Patient Name: _____
DOB: _____
MRN: _____

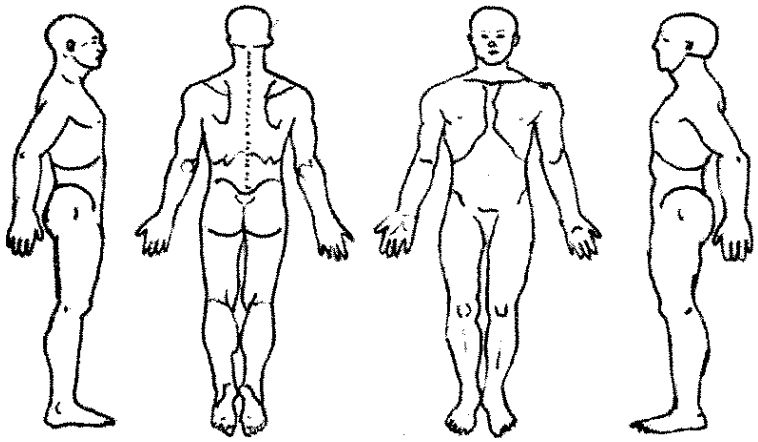
Patient Health Questionnaire – PHQ

Date:_____ Height: _____
Age: _____ Weight: _____

1. **Describe your symptoms.** _____
   _____

   a. When did your symptoms start? _____
   b. How did your symptoms begin? _____
   c. Is this problem work related? ☐ Yes ☐ No If yes, Date last worked? _____

2. **How often do you experience your symptoms? On the diagram, 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
   - ☐ Stiffness
   - ☐ Tingling

4. **Since they began, have your symptoms changed?**
   - ☐ Getting Better
   - ☐ Not Changing
   - ☐ Getting Worse

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

   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

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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 Doctor ☐ 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 Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other

10. **Were you hospitalized for this problem?** ☐ **Yes** ☐ **No**
    If yes, location and dates: _____

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

12. **What type of exercise are you currently doing?** _____

13. **What is your occupation?**
    ☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson
    ☐ Laborer ☐ Homemaker ☐ Student ☐ Other _____

    a. If you are not retired, a homemaker, or a student, what is your current work status?
       ☐ Full-time ☐ Self-employed ☐ Retired ☐ Part-time ☐ Unemployed
       ☐ Other

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

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

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16. Are you currently or have you in the past experienced any of the following?

☐ Balance Problems	☐ Drug/Alcohol Dependence	☐ Pelvic Pain
☐ Cardiac Problems	☐ Fibromyalgia	☐ Rheumatoid Arthritis
☐ Circulatory Problems	☐ High Blood Pressure	☐ Other: _____
☐ Depression	☐ Osteoarthritis	☐ Other: _____
☐ Dizzy Spells	☐ Pacemaker	☐ Other: _____

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

18. Are you pregnant? ☐ **Yes** ☐ **No**

19. List any prior surgeries or hospitalizations:

_____
_____
_____

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

_____
_____
_____

21. List any allergies and reaction to medications:

_____
_____
_____
_____
_____

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If you are being seen for your HIP or KNEE, please complete this section.

1. **Function**

a. **Limp**
- ☐ None
- ☐ Slight
- ☐ Moderate
- ☐ Severe
- ☐ Unable to Walk

b. **Distance Walked**
- ☐ Unlimited
- ☐ 6 Blocks
- ☐ 2-3 Blocks
- ☐ Indoors Only
- ☐ Bed to Chair

c. **Stairs**
- ☐ Normal
- ☐ Handrail Needed
- ☐ No Stairs

d. **Sitting**
- ☐ As long as needed
- ☐ Limited
- ☐ Uncomfortable

e. **Socks/Shoes**

Left	Right
☐ With Ease	☐ With Ease
☐ With Difficulty	☐ With Difficulty
☐ Unable	☐ Unable

f. **Cut Toenails**

Left	Right
☐ With Ease	☐ With Ease
☐ With Difficulty	☐ With Difficulty
☐ Unable	☐ Unable

2. **Do you have night pain?** ☐ Yes ☐ No
3. **Do you have pain while resting?** ☐ Yes ☐ No
4. **Do you have pain on arising from sitting?** ☐ Yes ☐ No
5. **Is your pain worsened by:**
   a. **Going upstairs?** ☐ Yes ☐ No
   b. **Going downstairs?** ☐ Yes ☐ No

KNEE ONLY

6. **Does your knee give out or buckle?** ☐ Yes ☐ No
7. **Does your knee "catch" or "Lock up"?** ☐ Yes ☐ No
8. **Can you squat?** ☐ Yes ☐ No