Patient Health Questionnaire - PHQ

ACN Group of California - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. *Describe your symptoms* _____

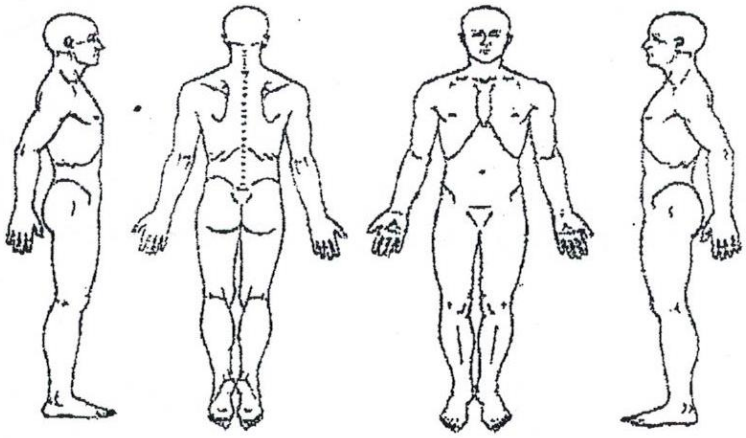
_____

a. *When did your symptoms start?* _____

b. *How did your symptoms begin?* _____

2. ***How often do you experience your 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)

Indicate where you have pain or other symptoms



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. *During the past 4 weeks:*

a. *Indicate the average intensity of your symptoms*

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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

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

6. ***During the past 4 weeks how much of the time has your condition interfered with your social activities?***
(like visiting with friends, relatives, etc)

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

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?* _____

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

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. *Have you had similar symptoms in the past?* ① Yes ② No

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

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. *What is your occupation?*

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

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

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Please check all of the following symptoms/conditions you are currently experiencing

- ☐ Abdominal cramping
- ☐ Adverse reaction to medical treatment
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anxiety/panic attacks
- ☐ Arthritis or rheumatism
- ☐ Asthma/wheezing
- ☐ Attempted suicide
- ☐ Birth trauma
- ☐ Bleeding disorder
- ☐ Bloating/gas
- ☐ Blood disease
- ☐ Brain fog or memory loss
- ☐ Candida
- ☐ Cancer or tumor
- ☐ Chronic fatigue
- ☐ Chest pain
- ☐ Constipation
- ☐ Coughing/sneezing
- ☐ COPD
- ☐ Cramps during menstruation
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty eating fatty/greasy foods
- ☐ Difficulty swallowing
- ☐ Digestive issues
- ☐ Dizziness or lightheadedness
- ☐ Double vision
- ☐ Eating disorder
- ☐ Epstein-Barr Disorder
- ☐ Fainting/loss of consciousness
- ☐ Fatigue
- ☐ Feeling of fullness
- ☐ Fever/chills
- ☐ Fibromyalgia
- ☐ Headaches or Migraines
- ☐ Heartburn
- ☐ Hepatitis/Liver Disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Insomnia
- ☐ Immune Disorder
- ☐ Indigestion/GERD
- ☐ Joint Pain
- ☐ Join Replacement
- ☐ Kidney Disorder
- ☐ Loss of appetite
- ☐ Low blood pressure
- ☐ Low or loss of libido
- ☐ Lupus
- ☐ Lyme’s Disease
- ☐ Lymph nodes removed
- ☐ Mental Illness
- ☐ Mercury/Metal Fillings
- ☐ Multiple Sclerosis
- ☐ Nerve pain
- ☐ Nausea/vomiting
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Painful urination
- ☐ Painful bowel movement
- ☐ PMS
- ☐ Polio
- ☐ Ringing in the ears
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizers/epilepsy
- ☐ Shortness of breath/emphysema
- ☐ Sinus congestion
- ☐ Sleep apnea
- ☐ Skin rash/eczema/skin conditions
- ☐ Sleep disturbed by pain
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary incontinence (frequency)
- ☐ Urinary tract or bladder infections
- ☐ Venereal Disease/STD
- ☐ Other: _____

Have you had any abdominal/pelvic surgeries? If so, please explain and list any complications (e.g, bleeding, infection, etc.).

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Do you have any other medical issues (past or present) not mentioned above?

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