Patient Health Questionnaire

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ACN Use Only rev 5/98

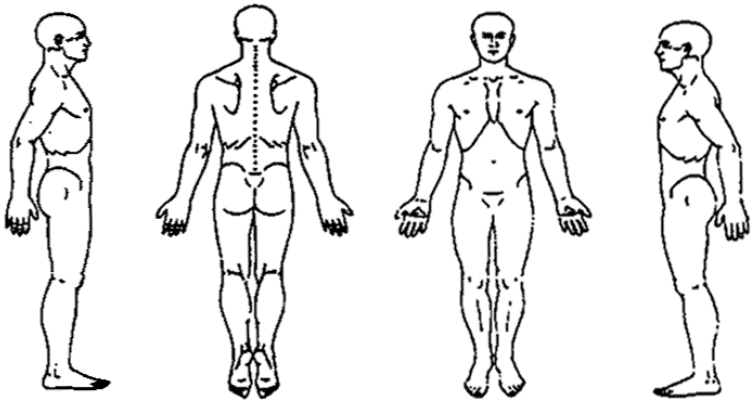
Patient Name _____ **Date** _____

When did your symptoms start? _____ **Describe your symptoms and how they began:**

_____

_____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

- ○ 1-Constantly (76-100% of day)
- ○ 2-Frequently (51-75% of day)
- ○ 3-Occasionally (26-50% of day)
- ○ 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?

- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

How are your symptoms changing?

- ○ 1-Getting Better
- ○ 2-Not Changing
- ○ 3-Getting Worse

What is the intensity of your symptoms at their:

	None									Unbearable
worst	①	①	②	③	④	⑤	⑥	⑦	⑧	⑨
best	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Who have you seen for this episode of your symptoms?

○ No one ○ Medical Doctor ○ Other
○ Other Chiropractor ○ Physical Therapist

When and what treatment? _____

Have you had the same or similar symptoms in the past? ○ Yes ○ No

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

○ This office ○ Medical Doctor ○ Other
○ Other Chiropractor ○ Physical Therapist

What tests have you had for your symptoms? ○ Xrays ○ CT Scan ○ MRI Scan ○ Other

What is your occupation?

_____

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

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

○ 1-Full-time ○ 4-Unemployed
○ 2-Part-time ○ 5-Employed, off work due to restrictions
○ 3-Self-employed ○ 6-Other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? ○ Yes ○ No

Describe your restrictions _____

What type of regular exercise do you perform? ○ 1-None ○ 2-Light ○ 3-Moderate ○ 4-Strenuous

What is your height and weight? Height ☐☐☐ (Feet Inches) Weight ☐☐☐ lbs.

Patient Signature _____ **Date** _____