Patient Health Questionnaire

Patient Name: _____ **DATE:** _____

1. **Describe your symptoms:** _____

_____

_____

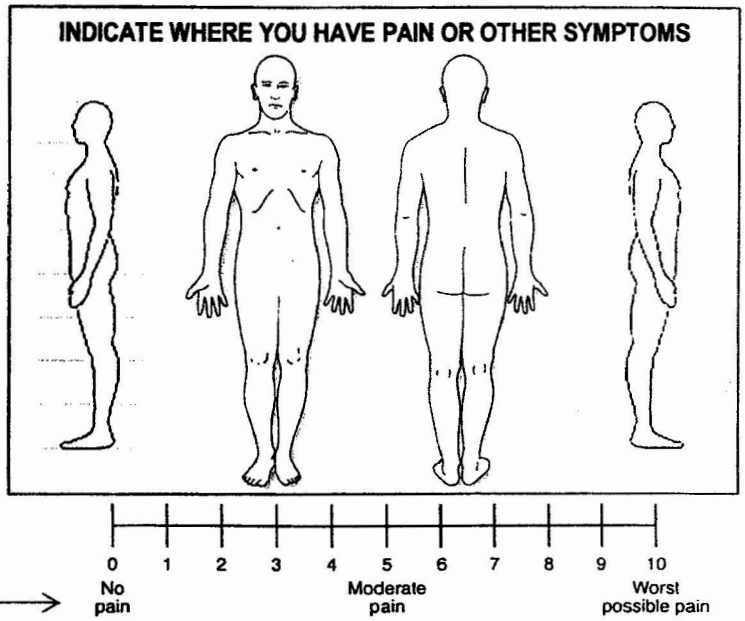
- ☐ *When did your symptoms start?* _____
- ☐ *How did your symptoms begin?* _____

2. **How often do you experience your symptoms?**
   - ☐ Constantly (76%-100% 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 ☐ Shooting ☐ Burning
   - ☐ Tingling ☐ Other: _____

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

INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



5. **During the past 4 weeks:**
   - *a) Circle the average intensity of your symptoms:* →
   - *b) How much has the pain interfered with your normal work (inside and outside the home)?*
   - ☐ 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 your social activities?**
   - ☐ Every time ☐ Most times ☐ Sometimes ☐ Rarely ☐ Not at all

7. **In general, would you say you overall health right now is:**
   - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. **Please, fill out including past and recent incidents:**

Who have you seen for the symptoms & when?	*Describe treatment administered:*	*Indicate tests & when:*
☐ No one		☐ X-ray _____
☐ Bay Area Neuromuscular _____	_____	☐ MRI _____
☐ Chiropractor _____	_____	☐ CT Scan _____
☐ Medical Doctor _____	_____	☐ Other _____
☐ Specialist _____ _____	_____	☐ Other _____
☐ Physical Therapist _____	_____	☐ Other _____

9. **What is your work status:** ☐ Full time ☐ Part time ☐ Retired Occupation: _____

Patient Signature: _____