PATIENT HEALTH QUESTIONNAIRE – PHQ

Please notify our office if your Insurance Carrier or coverage has changed

Please notify our office if your contact information has been changed since your last visit.

Patient Name _____ Date _____ GCC#_____

1. **Describe your symptoms (specify: Right Side-Left Side- front-back and mark drawing below)**

_____

_____

_____

When did your symptoms Start? Date_____

What describes the nature of your symptoms? Sharp / Shooting / Dull Ache / Burning /Numb / Tingling _____

How are your symptoms changing? Getting Better Getting Worse Not Changing

Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

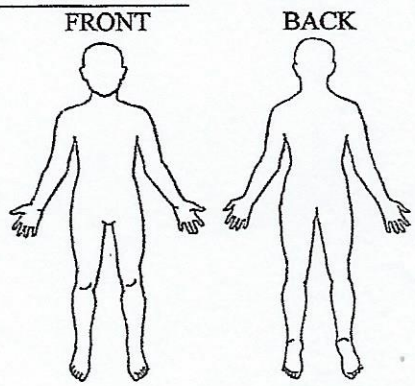
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How much have your symptoms interfered with your usual daily activities:

Not at all A little bit Moderately Quite a bit Extremely

How often do you experience your symptoms?

Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)



What makes you feel better_____

What activities aggravate your condition?_____

What can you no longer do since this episode/injury_____

Main reason(s) for consulting our office –Become Pain Free*Explanation of condition*Learn how to care for my condition Reduce symptoms*Resume normal activity level, such as_____

In general would you say your overall health right now a. Excellent b. Very good c. Good e. Fair d. Poor

What tests have you had for your symptoms and when were they performed? Radiology Facility_____

1. X-rays date: _____. 2. MRI date: _____. 3. CT Scan date_____. 4. Other date:_____.

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

If you have received treatment in the past for the same or similar symptoms, who did you see? 1. This office 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other Specify Name_____

Do you have Diabetes? Yes or No **Do you have High Blood Pressure?** Yes or No

Do you smoke? Yes or No **Do you consume caffeine?** Yes or No - **How much per day**_____

Do you drink Alcohol? Yes or No **How much per day** _____

Do you exercise? Yes or No **What forms**_____ **How often**_____

Height_____ **Weight**_____ **Blood Pressure**_____

List **Allergies to** *Food, Environment, Medication*_____

Current Medication and Dosage (or provide a list)

Medication Name_____ **Dosage**_____

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Medication Name_____ **Dosage**_____

List Fracture (s), Surgeries

"Dates"_____

I certify that the above information is correct and I request services.

Signature_____ Date_____