

Patient Health Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

1. Describe you symptoms \_\_\_\_\_

a. When did your symptoms start? \_\_\_\_\_

b. How did your symptoms begin? \_\_\_\_\_

2. Are your symptoms changing? (circle one) Getting better Not changing Getting worse  
Check the box if pain increase with: coughing..... sneezing..... straining.....

3. During the past 4 weeks: None unbearable

a. Indicate the average intensity of your symptoms 0 1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside the home and housework)  
(circle one)  
Not at all A little bit Moderately Quite a bit Extremely

4. During the past 4 weeks how much of the time has your condition interfered with your social activities, such as visiting with friends, relatives, etc? (circle one)

Not at all A little bit Moderately Quite a bit Extremely

5. In general would you say your overall health right now is... (circle one)

Excellent Very Good Good Fair Poor

6. Who have you seen for your symptoms? (circle all that apply)

No one Medical Doctor Physical Therapist Chiropractor Other

7. Have you had similar symptoms on the past? Yes No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?  
(circle all that apply)

No one Medical Doctor Physical therapist Chiropractor Other

8. What is your occupation? \_\_\_\_\_

9. How often do you experience your symptoms? (circle answer)

- a. Constantly (76-100% of the day)
- b. Frequently (51-75% of the day)
- c. Occasionally (26-50% of the day)
- d. Intermittently (0-25% of the day)
- e. Variable (sometimes worse than other times)
- f. Previously (no longer present)

10. What describes the nature of your symptoms? (circle all that apply)

- 1. Sharp
- 2. Shooting
- 3. Burning
- 4. Dull
- 5. Throbbing
- 6. Ache
- 7. Tingling
- 8. Numb
- 9. Heavy
- 10. Tight
- 11. Pulling
- 12. Stabbing

