Patient Health Questionnaire

First Name: _______________________ Initial: ______ Last Name: _____________________________________

Please describe your symptom(s):
______________________________________________________________________
________________________________________________________________________
___________________ ______________________________________________________

When did you symptom(s) start? ____________________________________________
How did you symptom(s) start – can you identify a reason for your symptoms?
________________________________________________________________________

How often do you experience your symptom(s)?
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (25-90% of the day)

Which term describes the nature of your symptom(s)?
□ Sharp   □ Numb   □ Burning   □ Dull ache   □ Shooting   □ Tingling

How are your symptom(s) changing?
□ Getting better □ Not changing □ Getting worse

During the past four weeks:
1. Indicate the average intensity of your symptom(s):   Very mild □ □ □ □ □ □ □ □ □ □ Unbearable
2. How much have your symptom(s) interfered with your normal daily work routine:
   □ Not at all □ A little bit □ Moderate □ Quite a bit □ A lot
3. How much have your symptom(s) interfered with your social activities:
   □ Not at all □ A little bit □ Moderate □ Quite a bit □ A lot

In general, would you say your overall health right now is:
□ Excellent □ Very good □ Good □ Fair □ Poor

Who have you seen for your symptom(s)?
□ No one □ Chiropractor □ Medical doctor □ Physical therapist □ Other: ______________________________

If you received treatment for your symptoms, please describe the type of treatment and when received:

What tests have you had for your symptom(s) and when?
□ X-Rays __________ □ MRI _________ □ CT Scan __________ □ Lab __________ □ Other ____________

Have you had a similar problem in the past? □ Yes □ No
If you have received treatment in the past for the same/similar symptoms, who did you see?
□ Logan □ Another chiropractor □ Medical doctor □ Physical therapist □ Other: ________________________

What is your occupation?
□ Professional/Executive □ White collar □ Tradesperson □ Laborer □ Homemaker □ Full time student
□ Retired □ Other

What is your current work status: □ Full-time □ Part-time □ Unemployed □ Off work

Signature: _____________________________ Date: _______________________

Updated: 3/27/14