

# Patient Health Questionnaire - PHQ

Form PHQ-202

Health Plan Use Only rev 7/18/05

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

## 1. Describe your symptoms

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

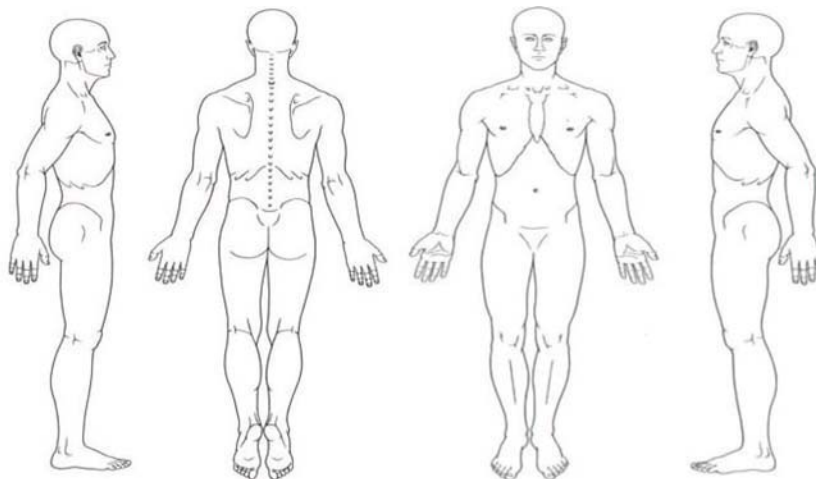
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

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



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

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

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all      ② A little bit      ③ Moderately      ④ Quite a bit      ⑤ Extremely

## 6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)Plan

- ① All of the time      ② Most of the time      ③ Some of the time      ④ A little of the time      ⑤ None of the time

## 7. In general would you say your overall health right now is...

- ① Excellent      ② Very Good      ③ Good      ④ Fair      ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One      ② Chiropractor      ③ Medical Doctor      ④ Physical Therapist      ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_      ③ CT Scan date: \_\_\_\_\_  
② MRI date: \_\_\_\_\_      ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes      ② No
- ① This Office      ③ Medical Doctor      ⑤ Other  
② Chiropractor      ④ Physical Therapist

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

## 10. What is your occupation?

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

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

- ① Full-time      ③ Self-employed      ⑤ Off work  
② Part-time      ④ Unemployed      ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_