Patient Health Questionnaire - PHQ

QC Pain & Wellness Center

Patient Name ______________________________ ***Date*** ______________

1. Describe your symptoms in detail: ______________________________

____

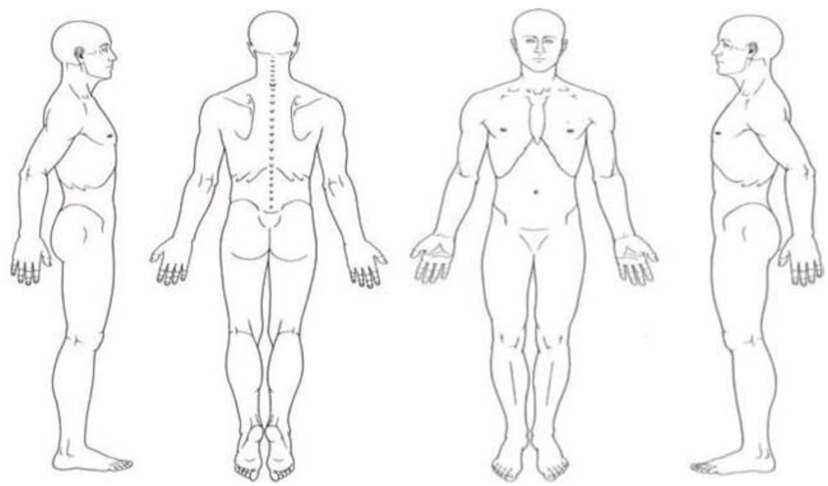
a. Date of onset? ______________________________

b. What caused your injury? ______________________________

2. How often do you experience your symptoms?

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

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

___ Sharp ___ Shooting
___ Dull ache ___ Burning
___ Numb ___ Tingling

4. How are your symptoms changing?

___ Getting Better
___ Not Changing
___ Getting Worse

5. Since your injury:

	None										*Unbearable*
a. Indicate the lowest intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10
b. Indicate the average intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10
c. Indicate the highest intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10

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

___ Not at all ___ A little bit ___ Moderately ___Quite a bit ___ Extremely

7. Since your injury how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

___ All of the time ___ Most of the time ___ Some of the time __A little of the time ___ None of the time

8. Who have you seen for this injury?

___ No One ___ Medical Doctor ___ Other____________
___ Chiropractor ___ Physical Therapist

a. What treatment did you receive and when? ______________________________

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

Xrays *date:* ____________ CT Scan *date:* ____________
MRI *date:* ____________ Other *date:* ____________

9. Are you taking any medication? ___ Yes ___ No

a. Indicate medications?
(Prescription and over-the-counter) ______________________________

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

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Patient Signature ______________________________ ***Date*** ______________