Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

Patient Name_____

Date

1. When did your symptoms start: ______ Describe your symptoms and how they began:

2. How often do you experience your symptoms	P Indicate where you have pain or oth	her 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) 					
 3. What describes the nature of your symptoms ① Sharp ② Dull ache ③ Numb ⑥ Tingling 					
 4. How are your symptoms changing? ① Getting Better ② Not Changing ③ Getting Worse 					
	None worst: 0 1 2 3 4 5 best: 0 1 2 3 4 5	Unbearable 6 7 8 9 0 6 7 8 9 0			
 6. How do your symptoms affect your ability to p ① ① ① ② ③ ① ② ③ ③ ① ② ③ ③ ③ ① ② ③ Ø <li< th=""><th>6 6 7 erferes Limiting, prevents Intense</th><th>(8) (9) (0) e, preoccupied seeking relief activity possible</th></li<>	6 6 7 erferes Limiting, prevents Intense	(8) (9) (0) e, preoccupied seeking relief activity possible			
9. Who have you seen for your symptoms?		③ Medical Doctor④ Other④ Physical Therapist			
a. When and what treatment?					
b. What tests have you had for your symptoms	① Xrays date: ③ CT	③ CT Scan date:			
and when were they performed?	② MRI date: ④ Oth	Other date:			
10. Have you had similar symptoms in the past?	1) Yes 2 No				
a. If you have received treatment in the past for the same or similar symptoms, who did you see		dical Doctor ⑤ Other /sical Therapist			
11. What is your occupation?		oorer ⑦ Retired memaker ⑧ Other Student			
 a. If you are not retired, a homemaker, or a student, what is your current work status? 12 What do you hope to get from your visit/treation of the statement o	② Part-time	f-employed ⑤ Off work employed ⑥ Other			

12. What do you hope to get from your visit/treatment (select all that apply):

- ⑦ Reduce symptoms③ Explanation of condition/treatment
- ② Resume/increase activity
 ④ Learn how to take care of this on my own

Patient Signature

Date _____

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(5) How to prevent this from occurring again

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Patien	t Name	Date							
What t	type of regular exercise do you	perform?	(1) O None	•	@Light		③ Moderate		
What	is your height and weight?		Height				Weight	lbs.	
				Feet	Inches				
	ach of the conditions listed belo presently have a condition liste						had the conc	lition in the past.	
Past	Present	Past	Present			Past	Present		
\bigcirc	○ Headaches	\bigcirc	○ High Blood Pre	ssure		\bigcirc	 Diabetes 	5	
\bigcirc	O Neck Pain	0	O Heart Attack			\bigcirc		/e Thirst	
\bigcirc	\odot Upper Back Pain	0	○ Chest Pains			0	○ Frequen	t Urination	
\bigcirc	O Mid Back Pain	0	⊖ Stroke						
\bigcirc	O Low Back Pain	0	○ Angina			0		/Use Tobacco Products	
\sim			0			\bigcirc		ohol Dependence	
0	O Shoulder Pain	0	○ Kidney Stones			\sim			
0	O Elbow/Upper Arm Pain	0	○ Kidney Disorde			0			
0	○ Wrist Pain	0	O Bladder Infectio			0			
0	○ Hand Pain	0	○ Painful Urinatio			0	O Systemi	•	
0	○ Hip/Upper Leg Pain	0	○ Loss of Bladde	r Conti	rol	0	 Epilepsy 		
0	\bigcirc Knee/Lower Leg Pain	\bigcirc	○ Prostate Proble	ems		\bigcirc		is/Eczema/Rash	
0	 Ankle/Foot Pain 	0	○ Abnormal Weig	nht Gai	in/Loss	0		S	
0		0	○ Loss of Appetit		11/2000	For	nalaa Only		
\bigcirc	\odot Jaw Pain	0	\bigcirc Abdominal Pain			Females Only			
		-		I		0	O Birth Co		
0	○ Joint Swelling/Stiffness	0				0		al Replacement	
0	○ Arthritis	0	⊖ Hepatitis			\bigcirc			
0	$^{\bigcirc}$ Rheumatoid Arthritis	0	○ Liver/Gall Blad	der Di	sorder	\bigcirc	\bigcirc		
0	$^{\bigcirc}$ General Fatigue	0	○ Cancer			Oth	er Health Pro	blems/Issues	
\bigcirc	\odot Muscular Incoordination	0	○ Tumor			0	0		
0	○ Visual Disturbances	0	◯ Asthma			0	0		
Ō	○ Dizziness	0	 Chronic Sinus 	itic		0	0		
		0		1115		0	0		
Indica	te if an immediate family memb	er has ha	nd any of the follow	ving:					
$\bigcirc R$	heumatoid Arthritis O Heart Pr	oblems	○ Diabetes	\odot Ca	ancer	0	Lupus O_		
		, -				-			
List al	ll prescription and over-the-cou	nter med	ications, and nutri	tional/	herbal su	pplen	nents you are	taking:	
List al	I the surgical procedures you h	ave had a	and times you have	e beer	n hospitali	zed:			
	· • ·								
						Date			
Docto	or's Additional Comments								
