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PATIENT HEALTH QUESTIONNAIRE - PHQ

Please list your symptoms below and the average relative discomfort intensity over the past 4 weeks:
(0 – 10) for each symptom.

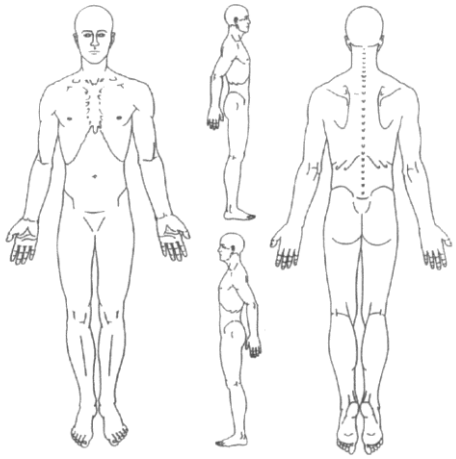
No Discomf. Mild Moderate Severe Unbearable
0 1 2 3 4 5 6 7 8 9 10

Symptoms: (*Example: Low back pain – 4*)

1) _____ 2) _____

3) _____ 4) _____

Please mark on the diagram to the right the following symbols as they relate to your symptoms:
SS= spasms ST= stiffness DP= dull pain SP= sharp pain
SH= shooting pain TI= tingling NU= numbness O= Other



PATIENT NAME:_____DATE:_____

When did your Symptoms start?_____
How often do you experience your symptoms?
____Constant (76-100% of the day) _____Frequently (51-75% of the day) ____Occasionally (26-50% of the d _____Intermittently (0-25% of the day)

In the past 4 weeks, how much has the discomfort interfered with your normal work duties?
_____Not at all _____A little bit _____Moderately _____Quite a bit _____Extremely

In the past 4 weeks, how much has the discomfort interfered with your everyday routine?
_____Constantly _____Most of the time _____Some of the time _____Rarely _____Never

How are your symptoms changing?
_____Getting Better _____Not Changing _____Getting Worse

What makes your symptoms worse?_____
What makes you symptoms better?_____

Who have you seen for your symptoms prior to today?_____
What treatment did they perform?_____

Have you had any tests performed for your symptoms? ____X-rays **date_____**
____**CT Scan** date_____ ____**MRI** date_____ ____**Other_____** date_____

Have you had similar symptoms in the past? ____Yes ____No
What type of treatment did you receive and whom did you see?_____
_____

PATIENT SIGNATURE:_____DATE:_____

For additional complaints see Wellness Questionnaire #_____DR. INITIALS_____