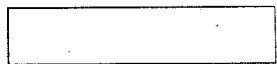


Patient Health Questionnaire - PHQ

Form PHQ-202



rev 7/18/05

Patient Name _____ Date _____

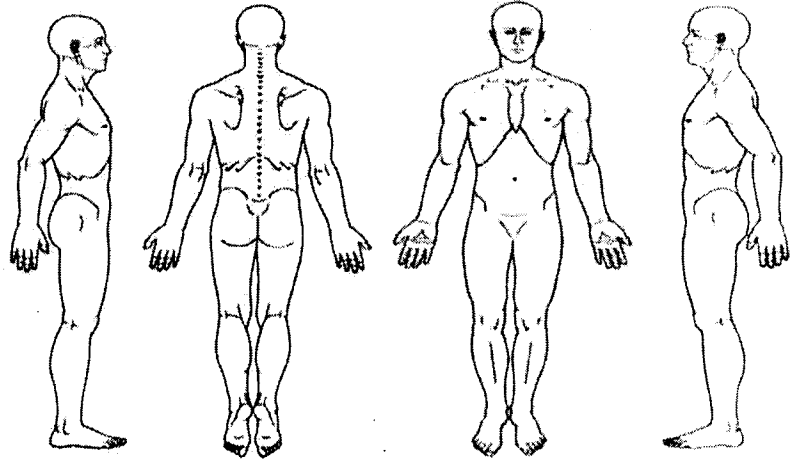
1. Describe your symptoms

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 ⑩ Unbearable

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)

- 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

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

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

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

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

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

Patient Signature _____ Date _____

CONFIDENTIAL PATIENT CASE HISTORY

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. THANK YOU

DATE _____
NAME _____ SS# _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
AGE _____ BIRTHDATE _____ SEX _____ MARRIED S D W NO. OF CHILDREN _____
OCCUPATION _____ EMPLOYER _____ BUS. PH. _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
SPOUSE'S NAME _____ OCCUPATION _____
REFERRED BY _____

HEALTH INFORMATION:

MAJOR COMPLAINT _____
WHEN DID YOU FIRST NOTICE THIS? _____ DOES THIS INTERFERE WITH WORK? _____
HAS THIS HAPPENED BEFORE? _____ WHEN? _____
WAS THIS CAUSED BY A FALL _____ ACCIDENT _____ STRAIN _____
HAVE YOU BEEN TREATED FOR THIS? _____ MD _____ DO _____ DC _____
NAME OF DOCTOR _____ DIAGNOSIS _____
TREATMENT _____ LENGTH OF CARE _____
LIST SURGICAL OPERATIONS AND YEARS: _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No
Do you have Health Insurance? _____ Yes _____ No If yes,
Name of Company _____ Policy # _____
Are you covered by Medicare? _____ Yes _____ No Supplement _____ Yes _____ No
If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date _____
Guardian or Spouse's Signature _____ S.S.# _____