

# Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

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

**1. Describe your symptoms**

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

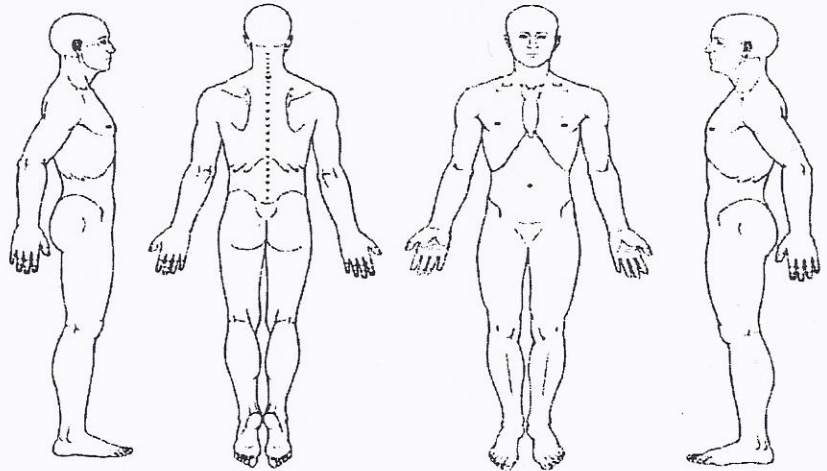
\_\_\_\_\_

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)**

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 Other 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 Other 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 INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

DATE \_\_\_\_\_

WERE YOU REFERRED TO A CERTAIN DOCTOR AT THIS CLINIC? IF SO, WHO? \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

IS YOUR VISIT DUE TO AN ACCIDENT?  YES  NO (IF YES, PLEASE COMPLETE BOTH SIDES.) WORK PHONE(\_\_\_\_\_) \_\_\_\_\_

## PATIENT DATA

NAME \_\_\_\_\_ HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ NUMBER OF CHILDREN \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_ SS# \_\_\_\_\_

NAME OF NEAREST RELATIVE \_\_\_\_\_ PHONE NUMBER (\_\_\_\_\_) \_\_\_\_\_

NAME OF WIFE OR HUSBAND \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ SS# \_\_\_\_\_ CLOCK OR EMPL.# \_\_\_\_\_

## PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS \_\_\_\_\_

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION \_\_\_\_\_

## MEDICAL HISTORY (If any of the following are relevant to your medical history, please check the accompanying box.)

- |                                              |                                             |                                              |
|----------------------------------------------|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> CANCER              | <input type="checkbox"/> MUSCULAR DYSTROPHY | <input type="checkbox"/> RHEUMATIC FEVER     |
| <input type="checkbox"/> POLIO               | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> SCARLET FEVER       |
| <input type="checkbox"/> TUBERCULOSIS        | <input type="checkbox"/> CONVULSIONS        | <input type="checkbox"/> NERVOUSNESS         |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> EPILEPSY           | <input type="checkbox"/> ASTHMA              |
| <input type="checkbox"/> HEART TROUBLE       | <input type="checkbox"/> CONCUSSION         | <input type="checkbox"/> DIGESTIVE DISORDERS |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> DIZZINESS          | <input type="checkbox"/> SINUS TROUBLE       |
| <input type="checkbox"/> HEPATITIS           | <input type="checkbox"/> ARTHRITIS          | <input type="checkbox"/> BACKACHES           |
| <input type="checkbox"/> GERMAN MEASLES      | <input type="checkbox"/> NEURITIS           | <input type="checkbox"/> NUMBNESS            |
| <input type="checkbox"/> VENEREAL DISEASE    | <input type="checkbox"/> RHEUMATISM         | <input type="checkbox"/> ANEMIA              |

DESCRIBE THE OPERATIONS YOU'VE HAD: \_\_\_\_\_ WHEN? \_\_\_\_\_

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR?  YES  NO \_\_\_\_\_

DESCRIBE CONDITION \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION?  YES  NO WHAT KIND? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION? YES  NO  WHAT KIND? \_\_\_\_\_

ARE YOU PREGNANT?  YES  NO DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

## INSURANCE DATA (Clinic policy requires payment arrangements be made on the first visit.)

NAME OF PARTY RESPONSIBLE FOR PAYMENT \_\_\_\_\_ PHONE NO. (\_\_\_\_\_) \_\_\_\_\_

DO YOU HAVE INSURANCE?  YES  NO COMPANY \_\_\_\_\_

## PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE \_\_\_\_\_

SPOUSE'S INSURANCE \_\_\_\_\_

WORKERS' COMPENSATION \_\_\_\_\_

OTHERS \_\_\_\_\_

EMPLOYEE I.D. NO. \_\_\_\_\_

POLICY NO. \_\_\_\_\_

GROUP NO. \_\_\_\_\_

MEDICARE NO. \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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 \_\_\_\_\_

SPOUSE'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

If yours is an accidental injury, please complete the reverse side of this form as well.

# ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

DATE OF ACCIDENT \_\_\_\_\_ HOUR OF ACCIDENT \_\_\_\_\_ AM PM

TYPE OF ACCIDENT:  WORK RELATED  TRAFFIC  OTHER

## WORK RELATED ACCIDENT

EMPLOYER \_\_\_\_\_ TYPE OF BUSINESS \_\_\_\_\_

WAS ANY EQUIPMENT, MACHINERY AND/OR OBJECT RELATED TO ACCIDENT? WHAT KIND? \_\_\_\_\_

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER?  YES  NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?  YES  NO

## TRAFFIC ACCIDENT

WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT?  TRUCK  CAR  MOTORCYCLE  OTHER

WERE YOU A  DRIVER  PASSENGER  PEDESTRIAN?

IF A PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE CAR. \_\_\_\_\_

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED?  YES  NO MPH? \_\_\_\_\_

DID YOUR VEHICLE HIT OTHER VEHICLE/S  YES  NO WHERE? \_\_\_\_\_

DID OTHER VEHICLE/S HIT YOUR VEHICLE?  YES  NO WHERE? \_\_\_\_\_

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT?  YES  NO

WERE TRAFFIC CITATIONS ISSUED?  YES  NO TO WHOM? \_\_\_\_\_

DESCRIBE ACCIDENT INCLUDING CAUSE/S AND SURROUNDING CIRCUMSTANCES \_\_\_\_\_

## PRESENT COMPLAINT

- |                                                         |                                                          |                                                                  |
|---------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> HEADACHE                       | <input type="checkbox"/> PINS & NEEDLES IN ARMS/LEGS     | <input type="checkbox"/> ANXIETY                                 |
| <input type="checkbox"/> HEAD SEEMS TOO HEAVY           | <input type="checkbox"/> NUMBNESS IN FINGERS, ARMS, LEGS | <input type="checkbox"/> EXTREME FATIGUE                         |
| <input type="checkbox"/> HEAD & SHOULDERS TIRED & HEAVY | <input type="checkbox"/> CHEST PAIN                      | <input type="checkbox"/> INSOMNIA                                |
| <input type="checkbox"/> MENTAL DULLNESS                | <input type="checkbox"/> SHORTNESS OF BREATH             | <input type="checkbox"/> NEURITIS                                |
| <input type="checkbox"/> LOSS OF MEMORY                 | <input type="checkbox"/> EYE STRAIN                      | <input type="checkbox"/> FACE FLUSHED                            |
| <input type="checkbox"/> EQUILIBRIUM PROBLEMS           | <input type="checkbox"/> PAIN BEHIND EYES                | <input type="checkbox"/> FACE PALE                               |
| <input type="checkbox"/> DIZZINESS                      | <input type="checkbox"/> EYES SENSITIVE TO LIGHT         | <input type="checkbox"/> EXCESS PERSPIRATION                     |
| <input type="checkbox"/> FAINTING                       | <input type="checkbox"/> EYES LOSS OF FOCUS              | <input type="checkbox"/> DIGESTIVE DISORDERS                     |
| <input type="checkbox"/> TREMORS                        | <input type="checkbox"/> DOUBLE VISION                   | <input type="checkbox"/> NAUSEA, VOMITING                        |
| <input type="checkbox"/> PALPITATION                    | <input type="checkbox"/> EARS BUZZING/RINGING            | <input type="checkbox"/> DIARRHEA                                |
| <input type="checkbox"/> NECK PAIN                      | <input type="checkbox"/> LOSS OF TASTE                   | <input type="checkbox"/> CONSTIPATION                            |
| <input type="checkbox"/> NECK STIFFNESS                 | <input type="checkbox"/> LOSS OF SMELL                   | <input type="checkbox"/> DEPRESSION                              |
| <input type="checkbox"/> NECK MOTION RESTRICTED         | <input type="checkbox"/> SINUS TROUBLE                   | <input type="checkbox"/> SWOLLEN                                 |
| <input type="checkbox"/> UPPER BACK PAIN/STIFFNESS      | <input type="checkbox"/> EXTREME NERVOUSNESS             | <input type="checkbox"/> FEET/HANDS COLD                         |
| <input type="checkbox"/> MID BACK PAIN/STIFFNESS        | <input type="checkbox"/> TENSION                         | <input type="checkbox"/> DIFFICULTY IN PRO-<br>LONGED CAR RIDING |
| <input type="checkbox"/> LOW BACK PAIN/STIFFNESS        | <input type="checkbox"/> IRRITABILITY                    |                                                                  |
- DIFFICULTY IN EXCESSIVE  STANDING  WALKING  RIDING  BENDING.  
 NECK, LOW BACK PAIN & STIFFNESS UPON RISING.  
 PAIN RADIATING INTO  RIGHT ARM  RIGHT LEG  BOTH  LEFT LEG  LEFT ARM  BOTH  
 DIFFICULTY IN EXCESSIVE LIFTING.  LIGHT  MODERATE  HEAVY  REPETITIVE  
 PAIN RADIATING INTO  NECK  BASE OF SKULL  SHOULDER  ARMS  HIPS  LEGS  
DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION?  YES  NO IF SO, WHERE? \_\_\_\_\_  
HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE?  YES  NO

SYMPTOMS OTHER THAN ABOVE \_\_\_\_\_

## INSURANCE COMPANIES INVOLVED

INSURANCE COMPANY OF PARTY RESPONSIBLE FOR PAYMENT \_\_\_\_\_ CLAIM # \_\_\_\_\_

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER OR COMPANY REPRESENTATIVE ABOUT CLAIM? \_\_\_\_\_

HAS YOUR ATTORNEY ADVISED YOU IN THIS CASE?  YES  NO

ATTORNEY'S NAME, ADDRESS & TELEPHONE # \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_