Patient Health Questionnaire

Patient Name _____ ***Date*** _____

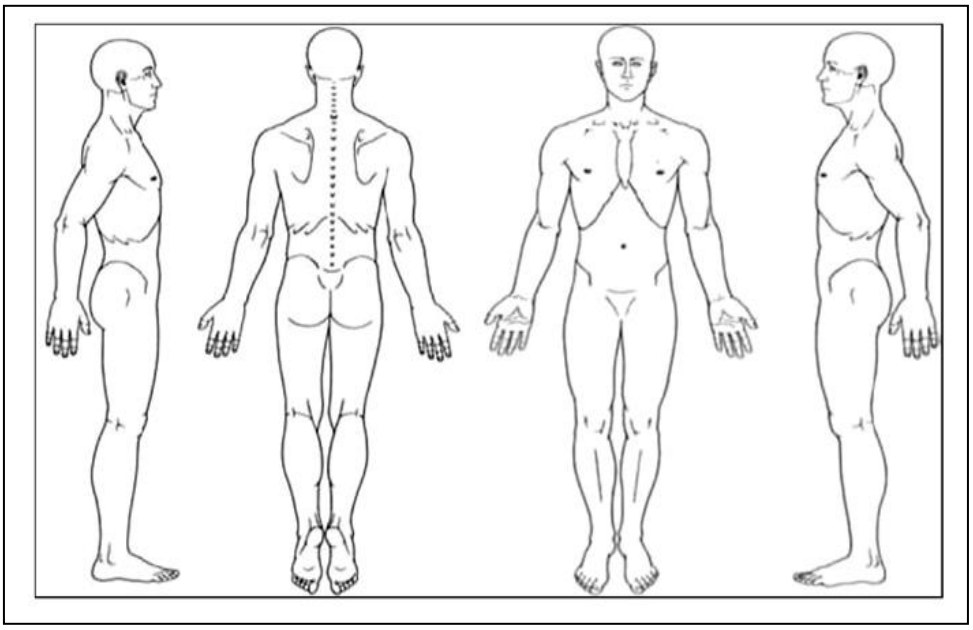
1. *When did your symptoms start:* _____ *Describe your symptoms and how they began:*

_____

_____

2. Please reference the scale below **(1) (2) (3) (4)** *to label the frequency of pain on the provided diagram:*

(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? (Please ✓any if applicable)

☐ Sharp ☐ Shooting
☐ Dull ache ☐ Burning
☐ Numb ☐ Tingling

4. How are your symptoms changing? (Please ✓any if applicable)

☐ Getting Better
☐ Not Changing
☐ Getting Worse

5. Any radiation into an extremity? ☐ Yes ☐ No (*if checked **yes**, please indicate where):* _____

_____

6. Have you done anything to treat this condition? ☐ Yes ☐ No (*if checked **yes**, please indicate how):* _____

_____

7. Have you taken any medication to treat this condition? ☐ Yes ☐ No (*if checked **yes**, please list medications):*

_____

_____

8. Have you had any previous injuries and/or procedures? (Please ✓any if applicable)

☐ Hospital/ Surgery
☐ Auto Accidents
☐ Job Accidents
☐ None
☐ Other (*if checked, please specify):*_____

_____

9. Please provide any additional information, comments or concerns:

_____

_____

_____

_____

Patient Signature _____ **Date**_____