Patient Health Questionnaire

Patient Name:_____ **Date:**_____

Date of Injury: _____**Describe your symptoms:**_____

_____

Is the condition getting: **Better** **Same** **Worse** **Came on:** **Gradually** **Immediately**

How often do you experience your symptoms?

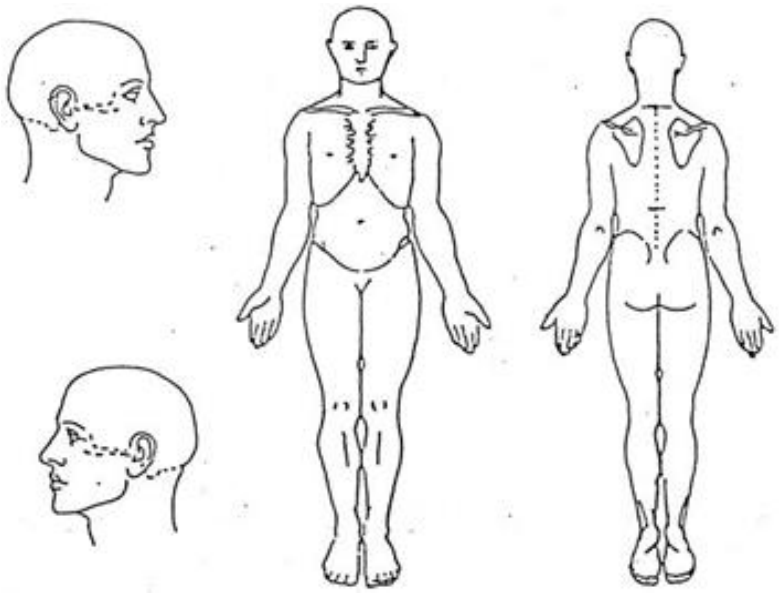
Constantly (76-100% of the day)

Frequently (51-75%)

Occasionally (26-50%)

Intermittently (0-25%)

Indicate where you have pain or other symptoms



What describes the nature of your symptoms?
(Circle all that apply)

Dull	Throbbing
Sharp	Burning
Aching	Numbing
Shooting	Tingling
Spasm	Other: _____

Do the symptoms travel to any of the following:

Arms Legs

Fingers Toes No Radiation

Does anything make the symptoms worse? (explain)_____

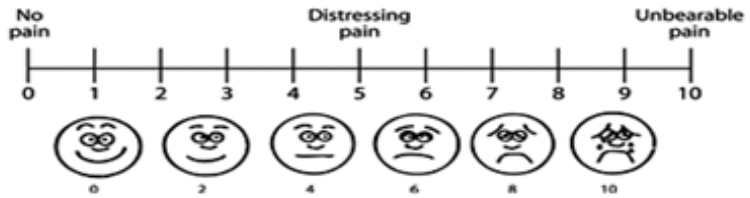
_____

Does anything make the symptoms better? (explain)_____

_____

Do the symptoms make it difficult to sleep?_____

Describe the level of your pain/symptoms:



What are your health goals?

_____

(For Office Use Only) Shoulder (L/R) Elbow (L/R) Hands (L/R) Clavicle (L/R) Ribs (L/R) Hip (L/R) Knee (L/R) Feet (L/R)

OCC C1 2 3 4 5 6 7 T1 2 3 4 5 6 7 8 9 10 11 12 L1 2 3 4 5 SAL SAR RPI LPI RAS LAS ANTPEL

Supine Cervical Drops C T L P S Activator Side Posture Anterior Board
Dry Hydrotherapy Interferential Intersegmental Traction Light/ Laser Therapy Muscle Therapy Biofreeze Orthosport