Patient Health Questionnaire - PHQ ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

| Patient Name | Date | | | |
|--|---|--|--|--|
| 1. Describe your symptoms | | | | |
| a. When did your symptoms start? | | | | |
| b. How did your symptoms begin? | | The state of the s | | |
| How often do you experience your symptoms? Constantly (76-100% of the day) | ndicate where you have pain or ot | her symptoms | | |
| © Frequently (51-75% of the day) | | | | |
| ③ Occasionally (26-50% of the day) | | | | |
| ⊕ Intermittently (0-25% of the day) | | (2-11-2) | | |
| 3. What describes the nature of your symptoms? ① Sharp | | | | |
| 4. How are your symptoms changing?① Getting Better② Not Changing③ Getting Worse | | | | |
| During the past 4 weeks:a. Indicate the average intensity of your symptoms | None ① ① ② ③ ④ ④ | Unbearable © © © © © | | |
| b. How much has pain interfered with your normal ① Not at all ② A little bit | | me, and housework) te a bit ⑤ Extremely | | |
| 6. During the past 4 weeks how much of the time had (like visiting with friends, relatives, etc.) | as your condition interfered with y | our social activities? | | |
| ① All of the time ② Most of the | time 3 Some of the time 4 A lif | ttle of the time S None of the time | | |
| 7. In general would you say your overall health righ | t now is | | | |
| ① Excellent ② Very Good | ⑤ Good | © Poor | | |
| 8. Who have you seen for your symptoms? | 9 110 One | dical Doctor | | |
| a. What treatment did you receive and when? | Name of the state | | | |
| b. What tests have you had for your symptoms | ① Xrays date: ③ CT | Scan date: | | |
| and when were they performed? | ② MRI date: ④ Oth | er daté: | | |
| 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? | THIS CHICE | dical Doctor | | |
| 10. What is your occupation? | White Collar/Secretarial | borer Ø Retired omemaker ® Other Student | | |
| a. If you are not retired, a homemaker, or a student, what is your current work status? | | If-employed | | |
| Patient Signature | Date | | | |

Patient Health Questionnaire - page 2 Managed Physical Network

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| What type of regular exercise do you perform? What is your height and weight? Height Foot Imbos For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column. If you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column. Past Present Past Present Past | Patient Name | | | Date | | MPN USO Only rev 5/7/99 | | |
|--|---|---|--------------------------|-------------------------------------|--|-------------------------|---------------------------------------|--|
| Weight Note | | | 7 | ① No | | | rate @ Strenuous | |
| For each of the conditions listed below, place a check in the Past Column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column. Past Present | | • | • | 11-2- | | ٦ | | |
| Poss Present Past Present O Headaches O Heart Attack O Excessive Thirst O Hirst O Heart Attack O Excessive Thirst O Heart Attack O Excessive Thirst O Hord Past O Heart Attack O Excessive Thirst O Hord Past O Excessive Thirst O Hord Past O Excessive Thirst O Excess | | o your noight and weight? | | neig | | vveigr | it lbs. | |
| Past Present | For ea | ach of the conditions listed belo presently have a condition listo | ow, place a ed below, | a check in the F place a check i | Past column if yo n the Present co | u have had the lumn. | e condition in the past. | |
| O Neck Pain O Heart Attack O Excessive Thirst O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Low Back Pain O Stroke O Drug/Alcohol Dependence O Depression O Bladder Infection O Depression O Depression O Painful Urination O Stroke O Depression O Depression O Painful Urination O Stroke O Depression O | | | | | | | | |
| O Neck Pain O Heart Attack O Excessive Thirst O Upper Back Pain O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Snoking/Use Tobacco Products O Low Back Pain O Angina O Drug/Alcohol Dependence O Shoulder Pain O Kidney Disorders O Allergies O Wrist Pain O Bladder Infection O Depression O Hand Pain O Painful Urination O Systemic Lupus O Hand Pain O Painful Urination O Systemic Lupus O Hip/Upper Leg Pain O Prostate Problems O Dermatitis/Eczema/Rash O Ankle/Foot Pain O Abnormal Weight Gain/Loss O Ankle/Foot Pain O Abdominal Pain O Described Bladder Disorder O Jaw Pain O Abdominal Pain O Pegnancy O Arthritis O Hepatitis O Hepatitis O Pregnancy O Remembold Arthritis O Hepatitis O Pregnancy O Remembold Arthritis O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O Visual Disturbances O Asthma O Visual Disturbances O Asthma O Remunatoid Arthritis O Heart Problems O Diabetes O Cancer Uppus O Remunatoid Arthritis O Heart Problems O Diabetes O Cancer Other Health Problems/Issues O Neck Pain Uppus Description, and over-the-counter medications, and nutritional/herbal supplements you are taking: Patient Signature Date | | O Headaches | 0 | O High Blood I | Pressure | O O Di | ahetes | |
| O Upper Back Pain O Stroke O Smoking/Use Tobacco Products O Mid Back Pain O Stroke O Drug/Alcohol Dependence O Shoulder Pain O Kidney Stones O Drug/Alcohol Dependence O Shoulder Pain O Kidney Stones O Allergies O Wrist Pain O Bladder Infection O Depression O Hand Pain O Painful Urination O Systemic Lupus O Hip/Upper Leg Pain O Prostate Problems O Dermatitis/Eczema/Rash O Kneel/Lower Leg Pain O Prostate Problems O Dematitis/Eczema/Rash O Ankle/Foot Pain O Abdominal Pain O Birth Control Pills O Jaw Pain O Abdominal Pain O Birth Control Pills O Joint Swelling/Stiffness O Ulcer O Hepatitis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Ulver/Gall Bladder Disorder O Rheumatoid Arthritis O Uriver/Gall Bladder Disorder O Muscular Incoordination O Tumor O Pregnancy O Dizziness O Cancer Other Health Problems/Issues O Dizziness O Chronic Sinusitis O Rheumatoid Arthritis O Heart Problems O Cancer O Lupus O List all prescription, and over-the-counter medications, and nutritional/herbal supplements you are taking: Date Provider's 'Additional Comments' | | | 8 | O Heart Attack | | | | |
| O Nind Back Pain O Stroke O Smoking/Use Tobacco Products O Low Back Pain O Kidney Stones O Drug/Alcohol Dependence O Shoulder Pain O Kidney Stones O Allergies O Elbow/Upper Arm Pain O Kidney Stones O Hinst Pain O Stones O Wrist Pain O Stones O Hinst Pain O Painful Urination O Systemic Lupus O Hand Pain O Painful Urination O Systemic Lupus O Hinp/Upper Leg Pain O Loss of Bladder Control O Epilepsy O Knee/Lower Leg Pain O Prostate Problems O Dermatitis/Eczema/Rash O Ands/Foot Pain O Abnormal Weight Gain/Loss O Jaw Pain O Abnormal Weight Gain/Loss O Jaw Pain O Abnormal Weight Gain/Loss O Joint Swelling/Stiffness O Ulcer O Birth Control Pills O Arthritis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Hepatitis O Pregnancy O General Fatigue O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O Pregnancy O Muscular Incoordination O Tumor O Pregnancy O Dizziness O Asthma O Chronic Sinusitis O Rheumatoid Arthritis O Heart Problems Diabetes Cancer Dupus O Chronic Sinusitis O Chronic Sinusitis O Rheumatoid Arthritis O Heart Problems Diabetes Cancer Dupus O Chronic Sinusitis Date State Problems Syou are taking: List all prescription, and over-the-counter medications, and nutritional/herbal supplements you are taking: Patient Signature Date | | | 0 | O Chest Pains | | | | |
| Shoulder Pain | | | 0 | ○ Stroke | | | • | |
| O Shoulder Pain O Kidney Stones C Elbow/Upper Am Pain O Kidney Disorders O Depression O Wrist Pain O Painful Utrination O Systemic Lupus O Hand Pain O Painful Utrination O Systemic Lupus O Hip/Upper Leg Pain O Prostate Problems O Demetitis/Eczema/Rash O Knee/Lower Leg Pain O Prostate Problems O Demetitis/Eczema/Rash O Ankle/Foot Pain O Abnormal Weight Gain/Loss O Jaw Pain O Loss of Appetite Females Only O Joint Swelling/Stiffness O Ulcer O Birth Control Pills O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement O Arthritis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Liver/Gall Bladder Disorder O General Fatigue O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O Wisual Disturbances O Asthma O Visual Disturbances O Asthma O Dizziness O Chronic Sinusitis O Dizziness O Cancer Lupus O Muscular Incoordination O Tumor O Machine Machine Machine Machine O Rheumatoid Arthritis O Heart Problems Diabetes O Cancer Lupus O Muscular Incoordination O Tumor O Machine Machine Machine Machine Machine Machine O Muscular Incoordination O Tumor O Machine O Muscular Incoordination O Tumor O Machine | O | O Low Back Pain | 0 | ○ Angina | | | | |
| O Elbow/Upper Arm Pain | 0 | O Shoulder Pain | 0 | O Kidney Stone | - 9 | 0 0 D r | ug/Alcohol Dependence | |
| O Wirst Pain O Bladder Infection O Depression O Perpession O Painful Urination O Systemic Lupus O Dermatitis Perpension O Painful Urination O Systemic Lupus O Dermatitis/Eczema/Rash O Prostate Problems O Dermatitis/Eczema/Rash O Prostate Problems O Dermatitis/Eczema/Rash O Prostate Problems O Dermatitis/Eczema/Rash O Normal Weight Gein/Loss O HIV/AIDS O HIV/AIDS O HIV/AIDS O Dermatitis/Eczema/Rash O Normal Weight Gein/Loss O HIV/AIDS O HIV/AIDS O Dermatitis/Eczema/Rash O Normal Weight Gein/Loss O HIV/AIDS O Dermatitis/Eczema/Rash O Divided Pain O Dermatitis/Eczema/Rash O Dermatitis/E | 0 | | | | | O O All | ergies | |
| O Hand Pain O Painful Urination O Systemic Lupus O Hip/Upper Leg Pain O Closs of Bladder Control O Epilepsy O Knee/Lower Leg Pain O Prostate Problems O Dematitis/Eczema/Rash O HIV/AIDS O Jaw Pain O Abdominal Pain O Birth Control Pills O Hormonal Replacement O Rheumatoid Arthritis O Liver/Gall Bladder Disorder O Pregnancy O General Fatigue O Cancer Other Health Problems/Issues O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Diabetes O Cancer O Lupus O Dizziness O Diabetes O Cancer O Lupus O Dizziness O Diabetes O Cancer O Lupus O Diabetes O Cancer O Diabetes O Diabetes O Cancer O Diabetes O Diabetes O Cancer O Diabetes O Diabetes | 0 | | | - | The state of the s | | | |
| O Hip/Upper Leg Pain O Closs of Bladder Control O Epilepsy O Knee/Lower Leg Pain O Prostate Problems O Demaitis/Eczema/Rash O Ankle/Foot Pain O Abnormal Weight Gain/Loss O HIV/AIDS O Ankle/Foot Pain O Closs of Appetite Females Only O Jaw Pain O Closs of Appetite Females Only O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement Pregnancy O Rheumatoid Arthritis O Liver/Gall Bladder Disorder O Pregnancy O General Fatigue O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O Dizziness O Dizziness O Asthma O Dizziness O Chronic Sinusitis O | O, | O Hand Pain | 0 | : = | | | • | |
| New Column O Prostate Problems O Dermatitis/Eczema/Rash O Ahonomal Weight Gain/Loss HIV/AIDS HIV/AIDS | \circ | O 111 71 | _ | | | -, | | |
| Ankle/Foot Pain | | O Hip/Upper Leg Pain | Ô | | | r | • • | |
| Jaw Pain | | | _ | | - | | | |
| O Jaw Pain O Abdominal Pain O Birth Control Pills O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement O Arthritis O Hepatitis O Pregnancy O Rheumatoid Arthritis O Liver/Gall Bladder Disorder O Cher Health Problems/Issues O General Fatigue O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O VIsual Disturbances O Asthma O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O Chronic Sinusitis O D Chronic Sinu | O ₁ | O Ankie/Foot Pain | | | | , | · · · · · · · · · · · · · · · · · · · | |
| O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement Arthritis O Hepatitis O Pregnancy Pregnancy O Rheumatoid Arthritis O Liver/Gall Bladder Disorder O Pregnancy O General Fatigue O Cancer Other Health Problems/Issues O Muscular Incoordination O Tumor O VIsual Disturbances O Asthma O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Diabetes O Cancer O Lupus O Chronic Sinusitis O Cancer O Chronic Sinusitis O Cancer O Chronic Sinusitis O Chronic Sin | 0 | ○ Jaw Pain | | • • | | Females Or | nly | |
| Arthritis | \circ | O tains 0 III (Out | _ | | ain ain | O O Bir | th Control Pills | |
| Reumatoid Arthritis | | | - | | | ○ ○ Ho | rmonal Replacement | |
| General Fatigue Genera | | | | • | | | | |
| O Muscular Incoordination O Tumor O O Tumor O O Nathma O O O Nathma O O Dizziness O O Asthma O O Dizziness O O Chronic Sinusitis O O O Chronic | 0 | O Rheumatold Arthritis | 0 | O Liver/Gall Bl | adder Disorder | 0 0 | | |
| O Muscular Incoordination O Tumor O Visual Disturbances O Asthma O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Dizziness O Diabetes O Cancer O Lupus O Dizination and over-the-counter medications, and nutritional/herbal supplements you are taking: List all the surgical procedures you have had and times you have been hospitalized: Patient Signature Date Provider's Additional Comments | 0 | ○ General Fatigue | 0 | O Cancer | | Other Heali | h Problems/Issues | |
| ○ Visual Disturbances ○ Asthma ○ O Chronic Sinusitis ○ O Indicate if an Immediate family member has had any of the following: ○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ Cancer ○ Cancer ○ Lupus ○ Cancer ○ Ca | 0 | | 0 | O Tumor | | | ii Frobleiiis/issues / | |
| O Dizziness O Chronic Sinusitis O Chronic Sinu | 0 | Visual Disturbances | 0 | | | | | |
| Cancer Cupus Cupus Cust all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: List all the surgical procedures you have had and times you have been hospitalized: Patient Signature Date Provider's Additional Comments | 0 | O Dizziness | | | usitis | | | |
| Cancer Cupus Cupus Cust all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: List all the surgical procedures you have had and times you have been hospitalized: Patient Signature Date Provider's Additional Comments | Indica | te if an immediate family memb | er has ha | d any of the foll | lowing: | | | |
| List all the surgical procedures you have had and times you have been hospitalized: Patient Signature | O R | neumatoid Arthritis O Heart Pr | roblems | | | O Lupus | 0 | |
| List all the surgical procedures you have had and times you have been hospitalized: Patient Signature | l iet al | I proceed the second | d = | ,, | | | | |
| List all the surgical procedures you have had and times you have been hospitalized: Patient Signature | | r prescription, and over-the-cou | nter meak | cations, and nu | | | | |
| Patient Signature | | , A . | | | • | | | |
| Patient Signature | List al | • | | | | | | |
| Patient Signature | *************************************** | | | | | | | |
| Provider's Additional Comments | n-4i | | | | | | | |
| Provider's Additional Comments | | | | | | Date | | |
| Declara Clauston | Provid | der's Additional Comments | | | | | | |
| Declara Clauston | | · | | | | | | |
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| | Docto | rs Signature | | | ' | | | |