Patient Health Questionnaire

Name: ____ **Date:** ____________________

What is the primary reason for your visit today? ____

Please describe your complaint: Sharp pain Dull pain Ache Throbbing Numbness Tingling Shooting Burning

Frequency of pain: Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

When and how did the symptoms begin? ____

____

Does the problem/pain radiate or travel to any other areas of the body? ____________________

Symptoms are worse in the: Morning Afternoon Night Same all day

Is the problem/pain interfering with: Work Sleep Recreation Daily Routine?

What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

Have you ever had treatment for this condition before? Yes No

If so, by whom and when? ____

List any other complaints: ____

Present Health Status

Height: _______Ft. _______In. Weight: __________ lbs.

Tobacco use: Never Seldom Moderate Frequent

Alcohol use: Never Seldom Moderate Frequent

List all medications you are currently taking: ____

____

Circle any symptom that you have experienced in the past or are experiencing now:

Neck pain	Jaw pain	Shoulder pain	Arm/elbow pain	Wrist/hand pain	Upper back pain	Hip or leg pain
Knee pain	Foot/ankle pain	Arthritis	Headaches	Seizures	Depression	Stiff swollen joints
Sleep problems	Asthma	Fatigue	Chest pain	Asthma	Emphysema	High Blood Pressure
Ulcers	Acid reflux	Hepatitis	Diabetes	Cancer	Kidney stones	Allergies/sinus trouble
Irritable Bowel	Aortic Aneurysm	Nervousness	Heart problems	Excessive weight gain/loss		

Have you been diagnosed with a permanent disability? Yes or No Percentage of disability __________%

Family Physician: ______________________ Date last seen: ______________________

List any other doctors being seen and why: ____

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Patient Signature: ________________________________ **Date:** ____________________