Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/1/05

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

   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?

   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?

   a. What treatment did you receive and when?

   b. What tests have you had for your symptoms and when were they performed?

9. Have you had similar symptoms in the past?

   a. If you have received treatment in the past for the same or similar symptoms, who did you see?

10. What is your occupation?

    a. If you are not retired, a homemaker, or a student, what is your current work status?

    Date ________________

Patient Signature __________________________