Patient Health Questionnaire

American Chiropractic Network

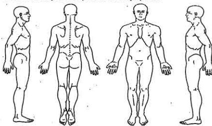
ACN Use Only rev 4/23/99

Patient Name______________________________ **Date**______________

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

2. How often do you experience your 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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?
① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse:______________________

8. What activities make your symptoms better:______________________

9. Who have you seen for your symptoms?
① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. When and what treatment?______________________

b. What tests have you had for your symptoms and when were they performed?
① Xrays date:__________ ③ CT Scan date:__________
② MRI date:__________ ④ Other date:__________

10. 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?
① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

11. What is your occupation?
① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply)*:
① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature______________________________ **Date**______________