Patient Health Questionnaire- PHQ

Medical Information_____

(Women) Are you pregnant: □ Yes □ No Nursing? □ Yes □ No

List any types of surgeries which you have had and the dates which they occurred:

_____

_____

Please list all medications that you are currently taking:

_____

_____

Allergies: _____

Is there any other condition you think the Doctor should know about?

_____

_____

Symptoms_____

Reason for visit: _____

When did you first notice the symptoms? _____

Is the condition getting progressively worse? _____

Which activities are difficult to perform? □ Sitting □ Standing □ Walking □ Bending □ Laying down □ Other

Type of pain: □ Sharp □Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □Swelling □ Other

Rate the severity of your pain (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What treatment have you received for your condition?

□ Medication □ Surgery □ Physical Therapy □ Other: _____

In general would you say your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Other Doctors seen for this condition? _____