

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

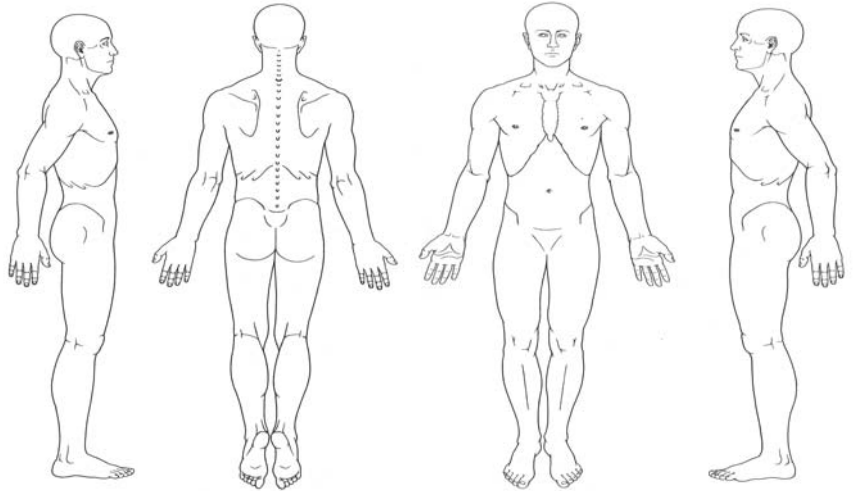
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began: _____

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. How bad are your symptoms at their:

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

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

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ 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: _____
- ② MRI date: _____
- ③ CT Scan 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 _____

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What type of regular exercise do you perform?

① None ② Light ③ Moderate ④ Strenuous

What is your height and weight?

Height

--	--	--

Feet Inches

Weight

--	--	--

 lbs.

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

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain

- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain

- Hip/Upper Leg Pain
- Knee/Lower Leg Pain
- Ankle/Foot Pain

- Jaw Pain

- Joint Swelling/Stiffness
- Arthritis
- Rheumatoid Arthritis

- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina

- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems

- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder

- Cancer
- Tumor
- Asthma
- Chronic Sinusitis

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination

- Smoking/Use Tobacco Products
- Drug/Alcohol Dependence

- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy
-

Other Health Problems/Issues

-
-
-

Indicate if an immediate family member has had any of the following:

- Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus _____

List 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 _____

Doctor's Additional Comments

Doctors Signature _____ Date _____