

Patient Health Questionnaire

Date _____

Patient Name _____

1. Describe your symptoms _____

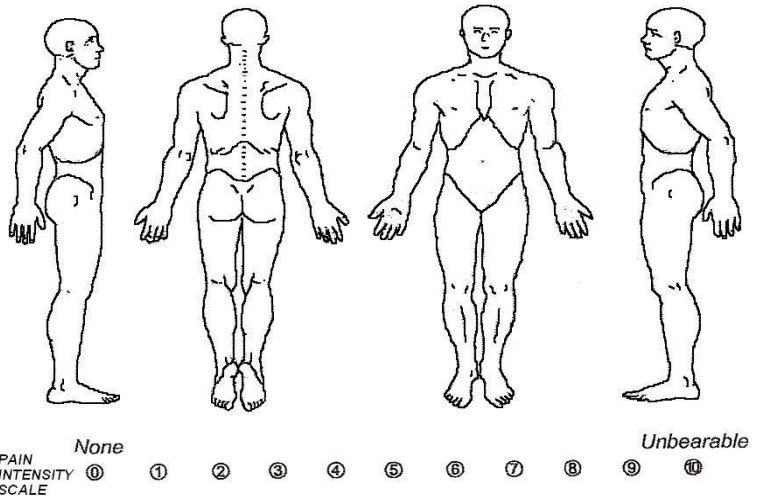
2. How long have you had symptoms? _____

3. What caused your symptoms? _____

4. Indicate on the diagram of the body where you have pain or symptoms and mark the numbers 1 through 10 that correspond with your least and most pain this week.

5. What describes your symptoms?

- a. sharp
- b. dull ache
- c. numb
- d. shooting
- e. burning
- f. tingling
- g. other _____



6. Are your symptoms changing?

- a. Getting Better
- b. Not Changing
- c. Getting Worse

7. What makes the symptoms worse? _____

8. What makes the symptoms better? _____

9. What other practitioners have you seen?

10. What treatments have you tried?

11. Have you had any testing?

XRAY _____ MRI _____ EMG _____ CT SCAN _____ OTHER _____

12. Have you had similar symptoms in the past? _____

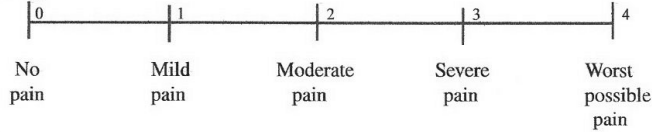
13. Have you missed work or school due this condition? _____

Functional Rating Index

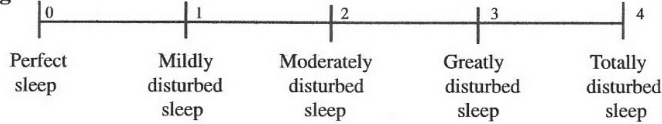
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

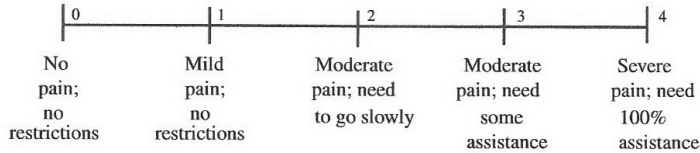
1. Pain Intensity



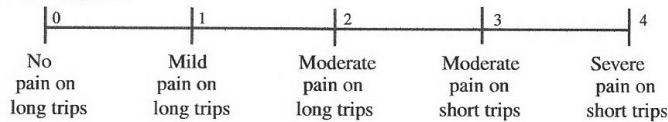
2. Sleeping



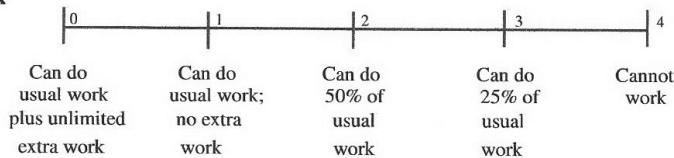
3. Personal Care (washing, dressing, etc.)



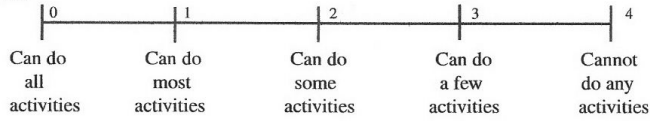
4. Travel (driving, etc.)



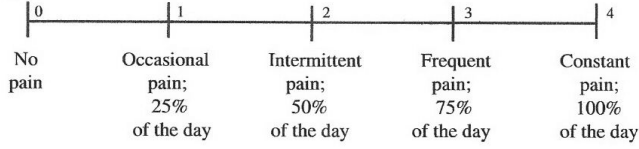
5. Work



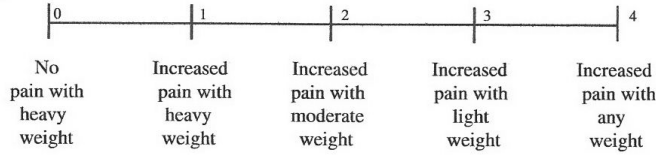
6. Recreation



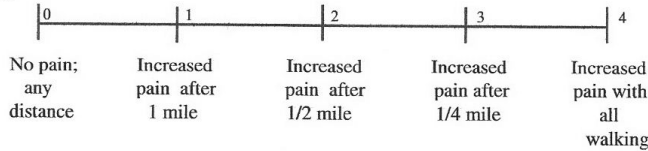
7. Frequency of pain



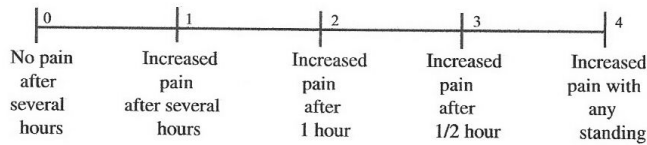
8. Lifting



9. Walking



10. Standing



Patient's Signature

Date