# 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:**

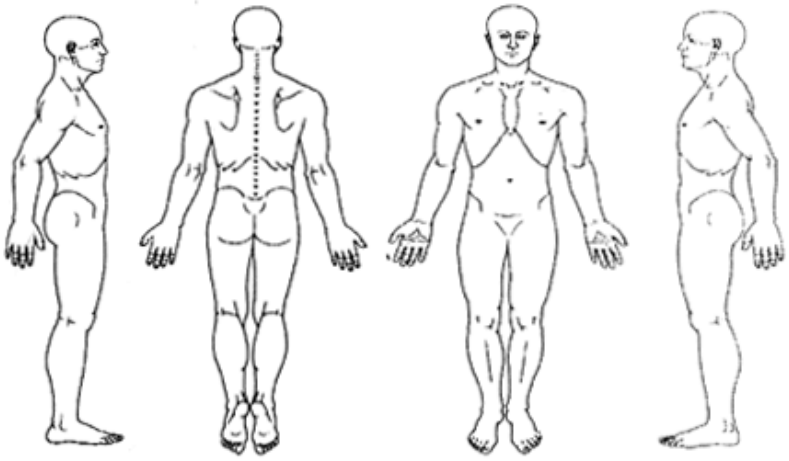
_____

_____

**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** _____