**PATIENT HEALTH QUESTIONAIRE**

1. Describe your symptoms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_a. When did they start?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_b. How did your symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often do you experience your symptoms?
2. Constantly (76-100% of the day)
3. Frequently (51-75% of the day)
4. Occasionally (26-50% of the day)
5. Intermittently (1-25% of the day)
6. What describes the nature of your symptoms?
7. Sharp (2) Dull ache
8. Numb (4) Shooting
9. Burning (6) Tingling
10. How are your symptoms changing?
11. Getting better
12. Getting Worse
13. No Change
14. During the past **4 weeks:**
15. Indicate the severity of your symptoms:

none unbearable

1. (2) (3) (4) (5) (6) (7) (8) (9) (10)
2. How much has pain interfered with your activities at work and outside of work?
3. Not at all (4) Quite a bit
4. A little bit (5) Extremely
5. Moderately
6. During the **past 4 weeks** how much has your condition interfered with your social activities?
7. All of the time (4) A little of the time

(2) Most of the time (5) None

(3) Some of the time

1. In general would you say your overall health right now is:
2. Exellent (4) Fair
3. Very Good (5) Poor
4. Good
5. Who else have you seen for your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. What treatment did you receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. What tests have you had and ***when*** were they performed?
8. X-ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3) CT scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. MRI \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (4) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Have you had similar symptoms in the past? YES NO

If yes where were you treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your occupation and work status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS**.

