

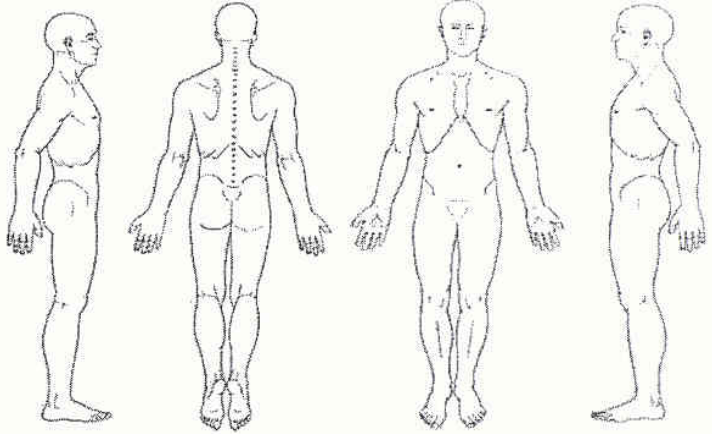
**Center for Rehabilitation Medicine  
Patient Health Questionnaire**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Describe your symptoms \_\_\_\_\_
  - a. When did your symptoms start? \_\_\_\_\_
  - b. How did your symptoms begin? \_\_\_\_\_

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. During the past 4 weeks:
  - a. Indicate the average intensity of your symptoms (0=none; 10=unbearable)
 

①   ②   ③   ④   ⑤   ⑥   ⑦   ⑧   ⑨   ⑩
  - b. How much pain interfered with your normal work (including both work outside the home & housework)
 

① Not at all      ② A little bit      ③ Moderately      ④ Quite a bit      ⑤ Extremely
6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
 

① All of the time    ② Most of the time    ③ Some of the time    ④ A little of the time    ⑤ None of the time

7. In general would you say your overall health right now is . . .
 

① Excellent          ② Very Good          ③ Good                  ④ Fair                  ⑤ Poor

8. Who have you seen for your symptoms?
 

① No one      ③ Medical Doctor    ⑤ Other  
② Chiropractor    ④ Physical Therapist
- a. What treatment did you receive and when? \_\_\_\_\_
- b. What tests have you had for your symptoms & when were they performed?
 

① Xrays date: \_\_\_\_\_    ③ CT Scan date: \_\_\_\_\_  
② MRI date: \_\_\_\_\_    ④ Other date: \_\_\_\_\_

9. 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                      ③ MD                      ⑤ Other  
② Chiropractor                  ④ PT

10. What is your occupation?
 

① Professional/exec.              ④ Laborer              ⑦ Retired  
② White collar/secretarial    ⑤ Homemaker    ⑧ Other  
③ Tradesperson                  ⑥ Student
11. If you are not retired, a homemaker, or a student, what is your current work status?
 

① Full-time                      ④ Self-employed      ⑦ Off work  
② Part-time                      ⑤ Unemployed        ⑧ Other

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_