**PHYSIOTHERAPHY NEW MEXICO**
**9 Frasco Way**
**Santa Fe, NM 87508**

# PATIENT HEALTH QUESTIONNAIRE

**PATIENT NAME:**_____ **DATE:**_____

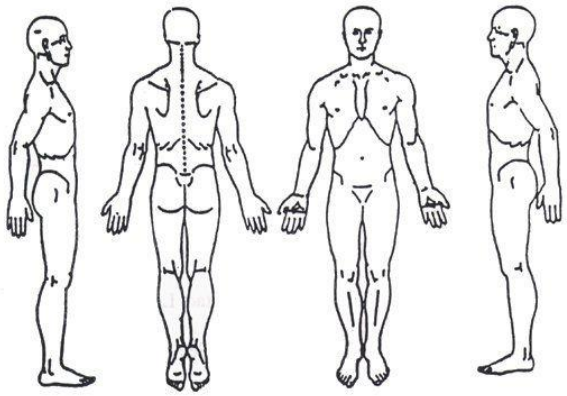
1. ***Describe your symptoms*** _____

   _____

   a. *When did your symptoms start?*_____

   b. *How did your symptoms begin?*_____

2. ***How often do you experience your symptoms? Indicate where you have pain or other symptoms:***
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)



3. ***What describes the nature of your symptoms?***
   - ☐ Sharp ☐ Shooting
   - ☐ Dull ache ☐ Burning
   - ☐ Numb ☐ Tingling
4. ***How are your symptoms changing?***
   - ☐ Getting Better
   - ☐ Not Changing
   - ☐ Getting Worse
5. ***During the past 4 weeks:*** ***None*** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ***Unbearable***
   a. *Indicate the average intensity of your symptoms*
   b. *How much has pain interfered with your normal work (including both work outside the home, and housework)*
      ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
6. ***During the past 4 weeks how much of the time has your condition interfered with your social activities?*** *(i.e. visiting friends, relatives, etc)*
   ☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
7. ***In general would you say your overall health right now is…***
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
8. ***Who have you seen for your symptoms?***
   ☐ No one ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other_____
   a. *What treatment did you receive and when?* _____
   b. *What tests have you had for your symptoms and when were they performed?*
   ☐ X-rays date:_____ ☐ MRI date: _____ ☐ MCT Scan date: _____ ☐ Other date: _____
9. ***Have you had similar symptoms in the past?*** ☐ Yes ☐ No
   a. If you have received treatment in the past for the same or similar symptoms, who did you see?
   ☐ This office ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other_____
10. ***What is your occupation?*** _____
    ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other_____

**PATIENT SIGNATURE:**_____ **DATE:**_____