PHYSIOTHERAPHY NEW MEXICO
9 Frasco Way
Santa Fe, NM 87508

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME:_____ **DATE:**_____

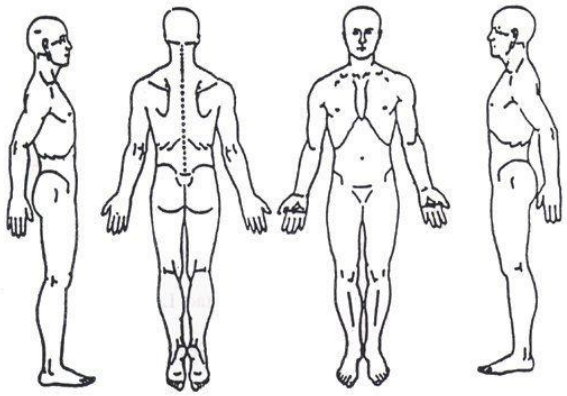
1. ***Describe your symptoms*** _____

   _____

   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:**_____