Patient Health Questionnaire ACN Group, Inc. Form PHQ-102

Date _____

Patient Name	Date				
1. When did your symptoms start:	Describe your symptoms and how they began:				
 2. How often do you experience your sympton 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) 	es? Indicate where you have pain or other symptoms				
 3. What describes the nature of your sympton ① Sharp ② Dull ache ③ Burning ③ Numb ⑥ Tingling 	s?				
4. How are your symptoms changing?① Getting Better② Not Changing③ Getting Worse					
5. How bad are your symptoms at their:	None Unbearable a. worst:				
6. How do your symptoms affect your ability t	perform daily activities?				
© ① ② ③ € No complaints Mild, forgotten Moderate, with activity with a	\$ \$\ \begin{align*} \				
7. What activities make your symptoms worse					
3. What activities make your symptoms better					
9. Who have you seen for your symptoms?	 ① No One ② Other Chiropractor ③ Medical Doctor ⑤ Other ⑤ Physical Therapist 				
a. When and what treatment?					
b. What tests have you had for your sympton	s ① Xrays date: ③ CT Scan date:				
and when were they performed?	② MRI date:				
0. Have you had similar symptoms in the pas	t? ① Yes ② No				
a. If you have received treatment in the past the same or similar symptoms, who did you s					
11. What is your occupation?	 ① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student 				
a. If you are not retired, a homemaker, or a student, what is your current work status?	 ① Full-time ② Self-employed ② Off work ② Part-time ④ Unemployed ⑥ Other 				
12. What do you hope to get from your visit/tr	eatment (select all that apply):				
	of condition/treatment				

Patient Signature_____

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Doctors Signature

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Date _____

Patien	t Name			Date				
What type of regular exercise do you perform? What is your height and weight?			① None	@Light		3 Moderate	Strenuous Ibs.	
			Height	Feet Inches		Weight		
	nch of the conditions listed belo presently have a condition list					had the cond	lition in the past.	
Past	Present	Past	Present		Past	Present		
\circ	Headaches	\circ	O High Blood Press	sure	\circ	Diabetes	3	
0	O Neck Pain	\circ	 Heart Attack 		\circ	○ Excessiv	ve Thirst	
0	O Upper Back Pain	\circ	 Chest Pains 		\circ	○ Frequen	t Urination	
0	O Mid Back Pain	\circ	○ Stroke			O 0 1:	,,, <u> </u>	
\circ	○ Low Back Pain	\circ	○ Angina		0		/Use Tobacco Products	
0	O Shoulder Pain	0	○ Kidney Stones		0	O Drug/Aid	ohol Dependence	
0	Elbow/Upper Arm Pain	0	Kidney Disorders	;	0	 Allergies 	;	
0	○ Wrist Pain	0	Bladder Infection		-	Depress		
0	Hand Pain	0	Painful Urination			Systemi		
		0	O Loss of Bladder (Control		Epilepsy	•	
0	○ Hip/Upper Leg Pain	0	O Prostate Problem			Dermatit	is/Eczema/Rash	
0	○ Knee/Lower Leg Pain	Ü				HIV/AID	S	
○ O Ankle/Foot Pain			Abnormal Weigh	t Gain/Loss				
0	○ Jaw Pain		Loss of Appetite		Fen	nales Only		
			Abdominal Pain		\circ	O Birth Cor	ntrol Pills	
0	 Joint Swelling/Stiffness 		Ulcer		\circ	O Hormona	al Replacement	
O O Arthritis Hep			Hepatitis	epatitis O Pregnancy			су	
\circ	 Rheumatoid Arthritis 		Liver/Gall Bladde	er Disorder	\circ	\circ		
	General Fatigue		Cancer		Oth	er Health Pro	blems/Issues	
Muscular Incoordination			Tumor		0 0			
Visual Disturbances		Asthma		_	0 0			
	Dizziness		Chronic Sinusiti	2	0	0		
○ RI	te if an immediate family member to the if an immediate family member the could be a secured to the could be a secure to	roblems	Diabetes	○ Cancer		Lupus O_	taking:	
List al	I the surgical procedures you h	nave had	and times you have	been hospital	ized:			
Patient Signature					Date			
Docto	r's Additional Comments							