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

ACN Group, Inc. Use Only rev 3/27/2003

Date \_\_\_\_\_

Patient Name	Date				
1. When did your symptoms start:	Describe your symptoms and how they began:				
<ul> <li>2. How often do you experience your symptoms?</li> <li>① Constantly (76-100% of the day)</li> <li>② Frequently (51-75% of the day)</li> <li>③ Occasionally (26-50% of the day)</li> <li>④ Intermittently (0-25% of the day)</li> </ul>	Indicate where you have p	ain or other symptoms			
<ul> <li>3. What describes the nature of your symptoms?</li> <li>① Sharp</li> <li>② Dull ache</li> <li>③ Burning</li> <li>③ Numb</li> <li>⑥ Tingling</li> </ul>					
<ul><li>4. How are your symptoms changing?</li><li>① Getting Better</li><li>② Not Changing</li><li>③ Getting Worse</li></ul>					
		Unbearable  (4			
6. How do your symptoms affect your ability to per  © ① ② ③ ④  No complaints Mild, forgotten Moderate, inter with activity with activity  7. What activities make your symptoms worse:	⑤ ⑥ ⑥ feres Limiting, prevents	7) ® ® 60  Intense, preoccupied Severe, no with seeking relief activity possible			
8. What activities make your symptoms better:					
9. Who have you seen for your symptoms?	No One     Other Chiropractor	<ul><li> Medical Doctor</li><li> Other</li><li> Physical Therapist</li></ul>			
a. When and what treatment?					
b. What tests have you had for your symptoms	① Xrays date:	③ CT Scan date:			
and when were they performed?	② MRI date:				
10. 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?	This Office     Other Chiropractor	<ul><li> Medical Doctor</li><li> Other</li><li> Physical Therapist</li></ul>			
11. What is your occupation?	<ul><li>① Professional/Executive</li><li>② White Collar/Secretarial</li><li>③ Tradesperson</li></ul>	<ul><li> Laborer</li><li> Retired</li><li> Homemaker</li><li> FT Student</li></ul>			
a. If you are not retired, a homemaker, or a student, what is your current work status?	① Full-time ② Part-time	<ul><li>3 Self-employed</li><li>4 Unemployed</li><li>5 Off work</li><li>6 Other</li></ul>			
12. What do you hope to get from your visit/treatm  ① Reduce symptoms ② Resume/increase activity ④ Learn how to tak		<ul><li>⑤ How to prevent this from occurring again</li><li>⑥</li></ul>			

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

## Patient Health Questionnaire - page 2

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What is your height and weight?  For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.  Past Present  Past Present  Headaches  Headaches  Height  Past Present  Pa	Patien	nt Name		Da	te		
For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.  Past Present  High Blood Pressure  High Blood Presser  High Blood Presser  High	What type of regular exercise do you perform?			① None ② Lig	nt	3 Moderate	rate
For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.  Past Present    Past Present   Past Present   O Diabetes   D Date   D Dat	What is your height and weight?				Weight	lbs.	
Headaches				a check in the Past column if y		e had the cond	lition in the past.
O Neck Pain O Heart Attack O Excessive Thirst O Heart Attack O Duper Back Pain O Chest Pains O Chest Pains O Frequent Urination O Mid Back Pain O Stroke O Dupy Alcohol Dependence O Stroke O Dupy Alcohol Dependence O Depression O Dupy Alcohol Dependence O Depression O Depressio	Past	Present	Past I	Present	Pas	t Present	
Output Back Pain Othest Pains Othest Pain Othest Pains Othest Othest Pains Othe	$\circ$	○ Headaches	$\circ$	O High Blood Pressure	0	<ul><li>Diabetes</li></ul>	3
O Mid Back Pain O Stroke O Smoking/Use Tobacco Produce Country Countr	$\circ$		$\circ$	O Heart Attack	$\circ$	○ Excessiv	e Thirst
Low Back Pain		• • •	$\circ$	O Chest Pains	$\circ$	○ Frequen	t Urination
Shoulder Pain	_		0	○ Stroke		0.00	/U. T.L D
Shoulder Pain	0	○ Low Back Pain	$\circ$	○ Angina			
Elbow/Upper Arm Pain	0	Shoulder Pain	0	○ Kidney Stones	0	O Drug/Aid	onoi Dependence
Wrist Pain			$\circ$		$\circ$	<ul> <li>Allergies</li> </ul>	<b>;</b>
Hip/Upper Leg Pain	$\circ$		$\circ$	-	$\circ$	-	
Hip/Upper Leg Pain	$\circ$	O Hand Pain	$\circ$	○ Painful Urination	$\circ$	O Systemi	c Lupus
Knee/Lower Leg Pain			0	O Loss of Bladder Control	$\circ$	<ul> <li>Epilepsy</li> </ul>	,
Ankle/Foot Pain			0	○ Prostate Problems	$\circ$	<ul><li>Dermatit</li></ul>	is/Eczema/Rash
O Jaw Pain O Abdominal Pain O Birth Control Pills O Joint Swelling/Stiffness O Ulcer O Hormonal Replacement O Hepatitis O Pregnancy Pregnancy O Hermonal Replacement O Hepatitis O Pregnancy O Hormonal Replacement O Hepatitis O Pregnancy O Pregnancy O Huscular Incoordination O Tumor O Husual Disturbances O Asthma O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Diabetes O Cancer Upus O Diabetes O Cancer O Huseufing O Diabetes O Diabetes O Cancer O Huseufing O Diabetes O Diabetes O Cancer O Huseufing O Diabetes O Diab		S .		Abnormal Weight Cain/Loss	$\circ$	O HIV/AID	S
Jaw Pain	0	○ Ankle/Foot Pain	_	_	_		
Joint Swelling/Stiffness	$\circ$	○ Jaw Pain	_	• •		-	
Arthritis		O 1 : 4 O 111 /OUT	_		0		
Rheumatoid Arthritis		_	_		_		•
Ogeneral Fatigue Ogene			_	•	0	•	су
○ Muscular Incoordination ○ Tumor ○ Ovisual Disturbances ○ Asthma ○ Ovisual Disturbances ○ Asthma ○ Ovisual Disturbances ○ Chronic Sinusitis ○ Ovisual Disturbances ○ Ovisual Disturbances ○ Chronic Sinusitis ○ Ovisual Disturbances ○ Ovisua	0	Rheumatoid Arthritis	0	○ Liver/Gall Bladder Disorder	0	0	
Muscular Incoordination Visual Disturbances Asthma Dizziness Indicate if an immediate family member has had any of the following: Rheumatoid Arthritis Heart Problems Diabetes Cancer List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking: List all the surgical procedures you have had and times you have been hospitalized: Patient Signature Date Doctor's Additional Comments	0	O General Fatique	$\circ$	○ Cancer	Ot	her Health Pro	blems/Issues
O Visual Disturbances O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Dizziness O Chronic Sinusitis O Dizziness O Dizziness O Chronic Sinusitis O Dizziness	$\circ$	•	$\circ$	○ Tumor	$\circ$	0	
O Dizziness O Chronic Sinusitis O Cancer O Chronic Sinusitis O C	$\circ$		$\circ$	○ Asthma	_		
○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○	0	O Dizziness			_		
List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:  List all the surgical procedures you have had and times you have been hospitalized:  Patient Signature	Indica	_		•			
List all the surgical procedures you have had and times you have been hospitalized:  Patient Signature  Doctor's Additional Comments	$\circ$ R	heumatoid Arthritis O Heart Pro	oblems	○ Diabetes ○ Cancer	(	C Lupus C_	
Patient Signature Date	List a	ll prescription and over-the-cour	nter medi	cations, and nutritional/herbal	supple	ments you are	taking:
Patient Signature Date							
Doctor's Additional Comments	List a	ll the surgical procedures you ha	ave had a	nd times you have been hospi	talized:	•	
Doctor's Additional Comments			_				
					_ Dat	e	
	Docto	r's Additional Comments					