PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____/_____/_____

1. Describe your symptoms: _____

_____

-How did your symptoms start: _____

_____

-Date your symptoms started: _____

2. How often do you experience your 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)

On a scale of 0 to 10, 0 being no pain at all and 10 being very severe pain please answer the following questions:

3. What is the least amount of pain you experience, on a pain scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

4. What is the most amount of pain you experience, on a pain scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

5. How would you describe your pain?

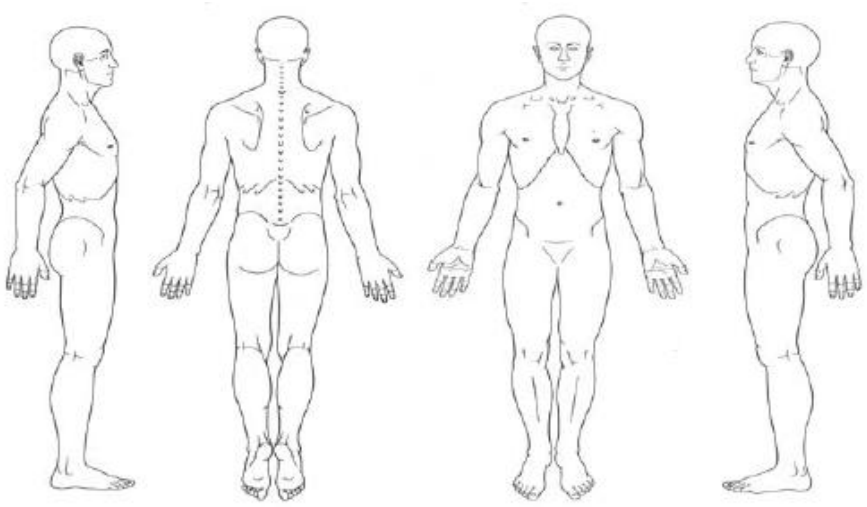
____Sharp	____Shooting	____Dull Ache	____Burning	____Numb
____Tingling	____Deadness	____Prickly	____Stabbing	____Hurting
____Pulsating	____Throbbing	____Crawling	____Pins & Needles	____Stinging
____Excruciating	____Pounding	____Headache	Other:_____	

6. If your pain or symptoms radiate or travel, please indicate the area: _____

7. Please indicate below where you are having the pain or symptom:

Use the Key to describe your pain:

A= Achy B= Burning C= Cramping T= Tingling
D= Dull N= Numb S= Stabbing



Patient Signature: _____ **Doctor Signature:** _____

8. What aggravates your symptoms? _____

9. What relieves your symptoms? _____

10. Please list below any symptoms you have had in the past or currently experiencing: ie-Dizziness, Cancer, Heart-attack, Stroke._____

11. In the past week my condition is: ____Improving ____Getting Worse ____About the same

12. Have you had similar symptoms in the past?

___Yes ___No *-If yes, who have you seen:* _____

13. Do you have a pacemaker? ___Yes ___No

14. (Females Only) Are you pregnant? ___Yes ___No

15. Please list any surgeries you have had:

a._____

b._____

c._____

d._____

16. Please list any medication and supplements you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

17. If you ARE taking vitamins or supplements, where do you get them from: _____

18. If you are NOT taking vitamins or supplements, would you be interested in learning more about them? Yes No

19. Please list any major injuries or hospitalizations you have had: _____

_____

_____

20. Do you have any family history of: Heart problems, Cancer, Diabetes, Other_____

Hobbies: _____

21. How is your diet and exercise? _____

Patient Signature_____ **Doctor Signature**_____