Patient Health Questionnaire

Name: _____ Date: _____

Describe your symptoms: _____

_____

_____

When did your symptoms appear: _____

How did your symptoms start: _____

Is your condition worsening: _____

Rate severity of pain 1-10 (1 almost no pain, 10 severe pain): _____

How often do you experience your symptoms (Please circle from list below):

76-100% of the day 51-75% of the day 26-50% of the day 0-25% of the day

What describes your symptoms (Please circle all that apply from list below):

Sharp Dull ache Numb Shooting Burning Tingling

How are your symptoms changing (Please circle from list below):

Getting Better Not Changing Getting Worse

Are your symptoms constant or does it come and go: _____

What makes it better: _____

What makes it worse: _____

Is there anything you cannot do: _____

Have you had similar symptoms in the past:_____

In general would you say your overall health now is (Please circle from list below):

Excellent Very Good Good Fair Poor

Who have you seen for your symptoms:

_____

_____

Have recent x-rays or MRI/CT scans been done (if so where): _____

_____

_____

Please mark your pain/symptoms on the diagram to the right.

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