

# PATIENT HEALTH QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

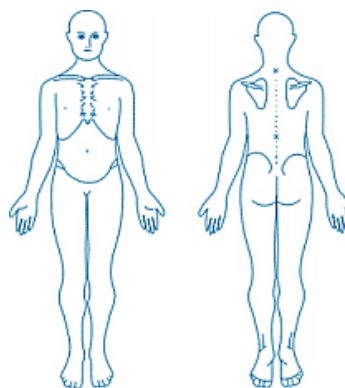
When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

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)

Indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

- Sharp
- Dull Ache
- Numb
- Shooting
- Burning
- Tingling

How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None Unbearable

1      2      3      4      5      6      7      8      9      10

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

During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)

- All of the time
- Most of the time
- Some of the time
- None of the time

In general would you say your overall health right now is.....

- Excellent
- Very Good
- Good
- Fair
- Poor

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: \_\_\_\_\_
- CT Scan: date: \_\_\_\_\_
- Other: date: \_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Height: \_\_\_\_ ft \_\_\_\_ in

Weight: \_\_\_\_\_ lbs.

What type of regular exercise do you perform?

- None
- Light
- Moderate
- Strenuous

**Check any conditions/symptoms past or present that may apply to you:**

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> Headaches                | <input checked="" type="checkbox"/> Bladder Infection            | <input checked="" type="checkbox"/> Allergies                           |
| <input checked="" type="checkbox"/> Neck Pain                | <input checked="" type="checkbox"/> Painful Urination            | <input checked="" type="checkbox"/> Depression                          |
| <input checked="" type="checkbox"/> Upper Back Pain          | <input checked="" type="checkbox"/> Loss of Bladder Control      | <input checked="" type="checkbox"/> Systemic Lupus                      |
| <input checked="" type="checkbox"/> Mid Back Pain            | <input checked="" type="checkbox"/> Prostate Problems            | <input checked="" type="checkbox"/> Epilepsy                            |
| <input checked="" type="checkbox"/> Low Back Pain            | <input checked="" type="checkbox"/> Abnormal Weight Gain/Loss    | <input checked="" type="checkbox"/> Dermatitis/Eczema/Rash              |
| <input checked="" type="checkbox"/> Shoulder Pain            | <input checked="" type="checkbox"/> Loss of Appetite             | <input checked="" type="checkbox"/> HIV/AIDS                            |
| <input checked="" type="checkbox"/> Elbow/Upper Arm Pain     | <input checked="" type="checkbox"/> Abdominal Pain               | <input checked="" type="checkbox"/> Birth Control Pills                 |
| <input checked="" type="checkbox"/> Wrist Pain               | <input checked="" type="checkbox"/> Ulcer                        | <input checked="" type="checkbox"/> Hormonal Replacement                |
| <input checked="" type="checkbox"/> Hand Pain                | <input checked="" type="checkbox"/> Hepatitis                    | <input checked="" type="checkbox"/> Pregnancy                           |
| <input checked="" type="checkbox"/> Hip/Upper Leg Pain       | <input checked="" type="checkbox"/> Liver/Gall Bladder Disorder  | <input checked="" type="checkbox"/> Rheumatoid Arthritis                |
| <input checked="" type="checkbox"/> Knee/Lower Leg Pain      | <input checked="" type="checkbox"/> Cancer                       | <input checked="" type="checkbox"/> General Fatigue                     |
| <input checked="" type="checkbox"/> Ankle/Foot Pain          | <input checked="" type="checkbox"/> Tumor                        | <input checked="" type="checkbox"/> Muscular Incoordination             |
| <input checked="" type="checkbox"/> Jaw Pain                 | <input checked="" type="checkbox"/> Asthma                       | <input checked="" type="checkbox"/> Visual Disturbances                 |
| <input checked="" type="checkbox"/> Joint Swelling/Stiffness | <input checked="" type="checkbox"/> Chronic Sinusitis            | <input checked="" type="checkbox"/> Dizziness                           |
| <input checked="" type="checkbox"/> Arthritis                | <input checked="" type="checkbox"/> Diabetes                     | <input checked="" type="checkbox"/> High Blood Pressure                 |
| <input checked="" type="checkbox"/> Heart Attack             | <input checked="" type="checkbox"/> Excessive Thirst             | <input checked="" type="checkbox"/> Other Health Problems/Issues: _____ |
| <input checked="" type="checkbox"/> Chest Pains              | <input checked="" type="checkbox"/> Frequent Urination           | _____   |
| <input checked="" type="checkbox"/> Stroke                   | <input checked="" type="checkbox"/> Smoking/Use Tobacco Products | _____   |
| <input checked="" type="checkbox"/> Angina                   | <input checked="" type="checkbox"/> Drug/Alcohol Dependence      | _____   |
| <input checked="" type="checkbox"/> Kidney Stones            |  |   |
| <input checked="" type="checkbox"/> Kidney Disorders         |  |   |

Indicate if an immediate family member has had any of the following:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Rheumatoid Arthritis | <input checked="" type="checkbox"/> Cancer       |
| <input checked="" type="checkbox"/> Heart Problems       | <input checked="" type="checkbox"/> Lupus        |
| <input checked="" type="checkbox"/> Diabetes             | <input checked="" type="checkbox"/> Other: _____ |

List ALL prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

\_\_\_\_\_  
\_\_\_\_\_

List ALL surgical procedures you have had and times you have been hospitalized:

\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## NECK INDEX

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

### Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain comes and goes and is moderate.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

### Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I can hardly read at all because of severe neck pain.
- I cannot read at all because of neck pain.

### Concentration

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want with slight difficulty.
- I have a fair degree of difficulty concentrating when I want.
- I have a lot of difficulty concentrating when I want.
- I have a great deal of difficulty concentrating when I want.
- I cannot concentrate at all.

### Work

- I can do as much work as I want.
- I can only do my usual work but no more.
- I can only do most of my usual work but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

### Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but I manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

### Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything at all.

### Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I cannot drive my car as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I cannot drive my car at all because of neck pain.

### Recreation

- I am able to engage in all my recreation activities without neck pain.
- I am able to engage in all my usual recreation activities with some neck pain.
- I am able to engage in most but not all my usual recreation activities because of neck pain.
- I am only able to engage in a few of my usual recreation activities because of neck pain.
- I can hardly do any recreation activities because of neck pain.
- I cannot do any recreation activities at all.

### Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

Index Score = {Sum of all statements selected / (# of sections with a statement selected x 5)} x 100

Neck Index Score

## Back Index

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

### Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is very severe and does not vary much.

### Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal sleep is reduced by less than 25%.
- Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced by less than 75%.
- Pain prevents me from sleeping at all.

### Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

### Standing

- I can stand as long as I want without pain.
- I have some pain while standing but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases pain immediately.

### Walking

- I have no pain while walking.
- I have some pain while standing but it does not increase with time.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

### Personal Care

- I don't have to change my way of washing or dressing in order to avoid pain.
- I don't normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

### Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.

### Traveling

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it worse.
- I get extra pain while traveling but none of my usual forms of travel make it worse.
- I get extra pain while traveling which causes me to seek alternate forms of travel.
- Pain restricts all forms of travel except that done while lying down.
- Pain restricts all forms of travel.

### Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

### Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Index Score = {Sum of all statements selected / (# of sections with a statement selected x 5)} x 100

Back Index Score