PATIENT HEALTH QUESTIONNAIRE

NAME _____ **DATE _____**

Is your problem related to: Auto Accident Work Injury Other

Date of Injury: _____

Describe your problem or pain:

_____

_____

_____

How would you describe your pain? Sharp Dull Achy Burning Other_____

Have you seen anyone else for this condition? If so, who:_____

When did symptoms begin?_____

Are your symptoms: constant OR intermittent (Circle one)

Rate your pain (Mild) 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 (Severe)

Are your symptoms: _____getting worse _____getting better _____not changing

What makes your condition better?_____

What makes your condition worse?_____

List all medications and vitamins you currently take _____

_____

List all current major health problems_____

_____

List all past health problems or trauma_____

_____

List all allergies _____

Do you smoke?_____ Do you exercise?_____ How is your diet?_____

(For Women) Are you pregnant?_____