

PATIENT HEALTH QUESTIONNAIRE

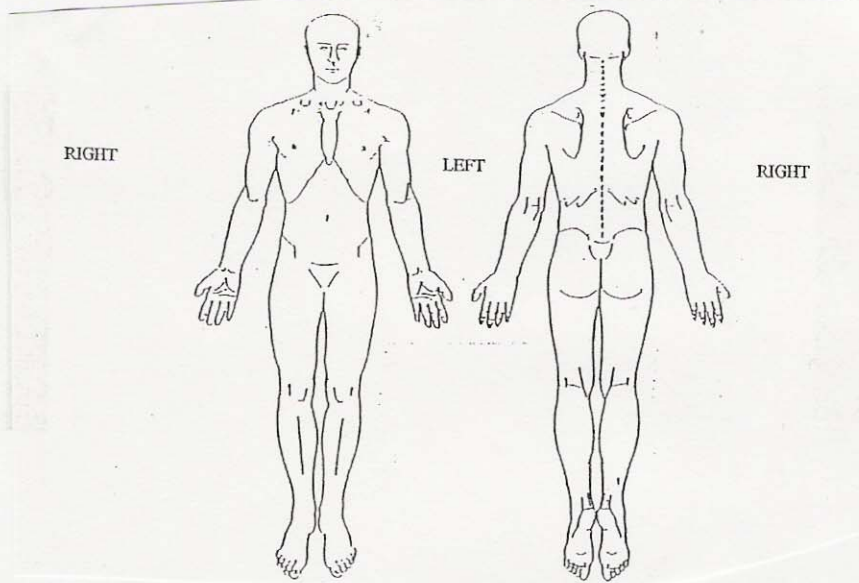
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What is your primary problem? \_\_\_\_\_

Describe the nature of your pain:

- |   |   |       |
|---|---|-------|
| <input type="checkbox"/> Constant (76-100%)         | <input type="checkbox"/> Sharp pain     | ////  |
| <input type="checkbox"/> Frequent (51-75%)          | <input type="checkbox"/> Dull pain      | ++++  |
| <input type="checkbox"/> Occasional (26-50%)        | <input type="checkbox"/> Throbbing      | ΔΔΔΔ  |
| <input type="checkbox"/> Intermittent (25% or less) | <input type="checkbox"/> Numbness       | ===== |
|   | <input type="checkbox"/> Shooting       | ●●●●  |
|   | <input type="checkbox"/> Burning        | XXX   |
|   | <input type="checkbox"/> Pins & needles | OOOO  |

Mark these drawings where you have pain or other symptoms, according to the symbols above:



Indicate the intensity of your pain at rest: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Indicate the intensity of your pain with movement: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Since this condition began your symptoms have:  Decreased  Remained the same  Increased

Your symptoms are worse in:  morning  afternoon  night  increased during the day  
 same all day

Any functional activities you're having difficulty with? \_\_\_\_\_