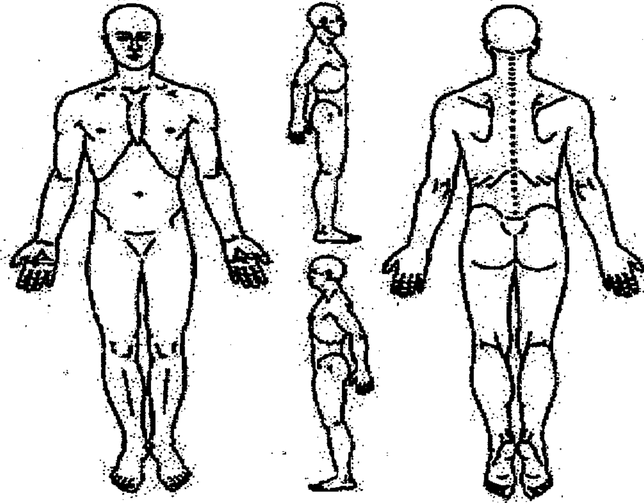
Name:________________________ Age:____ DOB:___/___/___ Date:________
Occupation:_______________________ Ht:_______ Wt:_______

**Primary Complaint**

Please indicate on Diagram where your feeling
**DP**=DullPain **SP**=SharpPain **A**=Achy pain, **N**=Numbness, **T**=Tingling **B**=Burning
and Draw a **LINE** where it is shooting indicating **T,N,B** or **P**



Constant (76-100% of day)
Frequent (51-75%)
Occasional (26-50%)
Intermittent (0-25%)

At it's **WORST** (please circle)
**1 2 3 4 5 6 7 8 9 10**
At it's **BEST**
**1 2 3 4 5 6 7 8 9 10**

*Please circle all that apply:*

| Sharp | Dull | Achy | Shooting | Numb | Tingling | Burning | Tight | Deep |
|---|---|---|---|---|---|---|---|---|
| __% | __% | __% | __% | __% | __% | __% | __% | __% |

Describe Chief Complaint: ________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Is it Overuse: Yes No And From What? ________________________________

How Long has it been going on:____________________
Is there any shooting pain Yes No (Please indicate on diagram above)
What **RELIEVES** It?________________________________________________
What **AGGRAVATES** it?______________________________________________
Have you had previous episodes? And Explain:___________________________
________________________________________________________________
Previous Care? Explain ______________________________________________
Xray- yes no when? __________ MRI- yes no when? _________
What Helped? ______________________________________________________

Is there anything else?_______________________________________________

IF YOU HAVE ANYTHER COMPLAINT, PLEASE PRINT OUT ADDITIONAL COMPLAINT PAGE

# Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** ______________________ **Date** ____________

**What type of regular exercise do you perform?** ☐ None ☐ Light ☐ Moderate ☐ Strenuous

**For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.**

| Past | Present | Condition |
|---|---|---|
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Mid Back Pain |
| ☐ | ☐ | Low Back Pain |
| ☐ | ☐ | Shoulder Pain |
| ☐ | ☐ | Elbow/Upper Arm Pain |
| ☐ | ☐ | Wrist Pain |
| ☐ | ☐ | Hand Pain |
| ☐ | ☐ | Hip/Upper Leg Pain |
| ☐ | ☐ | Knee/Lower Leg Pain |
| ☐ | ☐ | Ankle/Foot Pain |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Joint Swelling/Stiffness |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | General Fatigue |
| ☐ | ☐ | Muscular Incoordination |
| ☐ | ☐ | Visual Disturbances |
| ☐ | ☐ | Dizziness |

| Past | Present | Condition |
|---|---|---|
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Chest Pains |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Angina |
| ☐ | ☐ | Kidney Stones |
| ☐ | ☐ | Kidney Disorders |
| ☐ | ☐ | Bladder Infection |
| ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Loss of Bladder Control |
| ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Abnormal Weight Gain/Loss |
| ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Ulcer |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Liver/Gall Bladder Disorder |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Tumor |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Chronic Sinusitis |

| Past | Present | Condition |
|---|---|---|
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Smoking/Use Tobacco Products |
| ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Allergies |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | HIV/AIDS |

***Females Only***

| Past | Present | Condition |
|---|---|---|
| ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Pregnancy |
| ☐ | ☐ | |

***Other Health Problems/Issues***

| Past | Present | Condition |
|---|---|---|
| ☐ | ☐ | |
| ☐ | ☐ | |
| ☐ | ☐ | |

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

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ ____________

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

____________ ____________ ____________

____________ ____________ ____________

**List all the surgical procedures you have had and times you have been hospitalized:**

____________ ____________ ____________

____________ ____________ ____________

**Patient Signature** ______________________ **Date** ____________

**Doctor's Additional Comments**

______________________________________

______________________________________

______________________________________

**Doctors Signature** ______________________ **Date** ____________