PATIENT HEALTH QUESTIONAIRE

Patient Name ____ Date _______________

1. How often do you experience your symptoms?

   ☐ constant (100% of time) ☐ frequently (75% of time) ☐ occasionally (50% of time) ☐ intermittently (25% of time) ☐ rarely (10% of time)

2. Describe the nature of your pain.

   ☐ sharp ☐ dull ache ☐ numb ☐ shooting ☐ burning ☐ tingling
   ☐ fixed ☐ moving ☐ throbbing ☐ cramping ☐ can't explain

3. How are your symptoms changing?

   ☐ getting better ☐ no change ☐ getting worse

4. What makes it better?

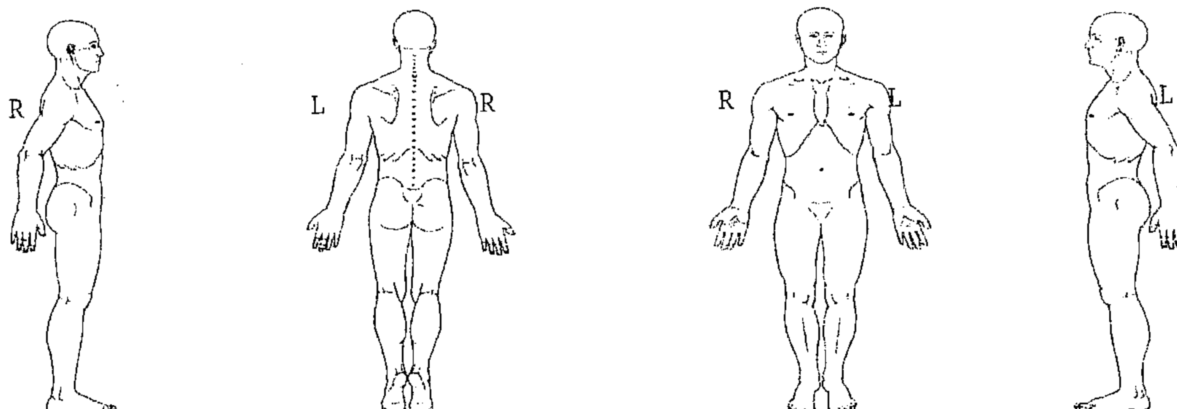
   ☐ rest ☐ exercise ☐ brace ☐ sitting ☐ standing ☐ cold pack ☐ hot pack
   ☐ medicine ☐ stretching ☐ moving around ☐ other ____________________________

5. What makes it worse?

   ☐ coughing/sneezing ☐ lifting ☐ bending ☐ pushing/pulling ☐ driving/riding/sitting
   ☐ walking/standing ☐ sleeping ☐ turning ☐ working ☐ other __________________

6. Mark areas of pain using the appropriate symbols indicated:

   Shooting (~~~~); Aching (//////); Numbness/Tingling (****); Sharp (.....); Burning (XXXX)



7. Indicate the average intensity of your symptoms during the past week

   0 1 2 3 4 5 6 7 8 9 10
   none -- unbearable

8. How much has pain interfere with your normal work and daily activities?

   ☐ none ☐ some ☐ moderately ☐ a lot ☐ extremely

Patient's Signature ____ Date _______________