Patient Health Questionnaire - PHQ

Mark Z Lipkin, DC
2595 Tampa Road, Suite P
Palm Harbor FL 34684

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

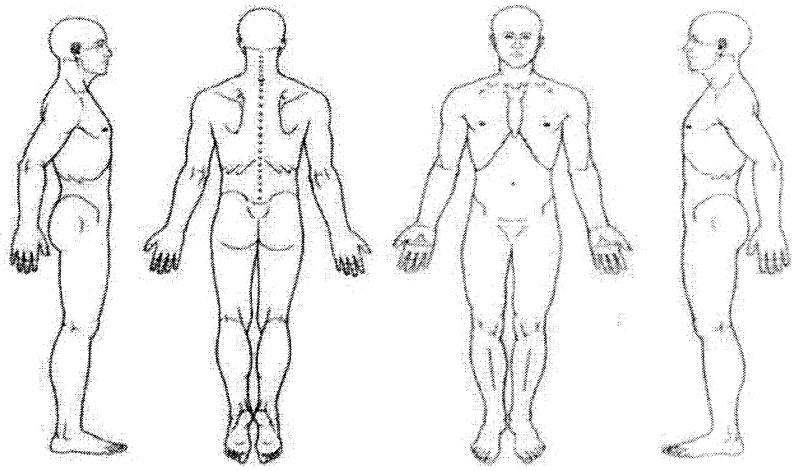
a. When did your symptoms start? Date} _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

(1) Constantly (76-100% of the day)
(2) Frequently (51-75% of the day)
(3) Occasionally (26-50% of the day)
(4) Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

(1) Sharp (4) Shooting
(2) Dull ache (5) Burning
(3) Numb (6) Tingling

4. How are your symptoms changing?

(1) Getting Better
(2) Not Changing
(3) Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

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

(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time

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

(1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

8. Who have you seen for your symptoms?

(1) No One
(2) Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

(1) Xrays *date:* _____ (3) CT Scan *date:* _____
(2) MRI *date:* _____ (4) Other *date:* _____

9. Have you had similar symptoms in the past?

(1) Yes (2) No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

(1) This Office
(2) Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

10. What is your occupation?

_____

(1) Professional/Executive
(2) White Collar/Secretarial
(3) Tradesperson
(4) Laborer
(5) Homemaker
(6) FT Student
(7) Retired
(8) Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

(1) Full-time
(2) Part-time
(3) Self-employed
(4) Unemployed
(5) Off work
(6) Other

Patient Signature _____ ***Date*** _____

(Print Name) Date

PATIENT INTAKE FORM (Page 2)

Mark Z Lipkin DC
2595 Tampa Rd. Suite P
Palm Harbor, FL 34684

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?

13. What concerns you the most about your problem; what does it prevent you from doing?

14. What alleviates your problem?

15. What is your: **Height**_____ **Weight** _____ **Age** _____ **Birth Date** _____

16. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

☐ **Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

☐ **Ears/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Respiratory**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

☐ **Genitourinary**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Female - date of last pap smear	_____	

☐ **Musculoskeletal**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Integumentary (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

☐ **Neurological**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

☐ **Endocrine**

Glandular or hormone problem.	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications: _____

Known food allergies: _____
ENVIRONMENTAL ALLERGIES

Heart Disease/cond.	No	Yes
HyperCholesterol	No	Yes
High Blood Pressure	No	Yes
Diabetes	No	Yes

26. Anything else pertinent to your visit today?_____

Patient Signature_____ ***Date:***_____

Doctor Note:
= present complaint