

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

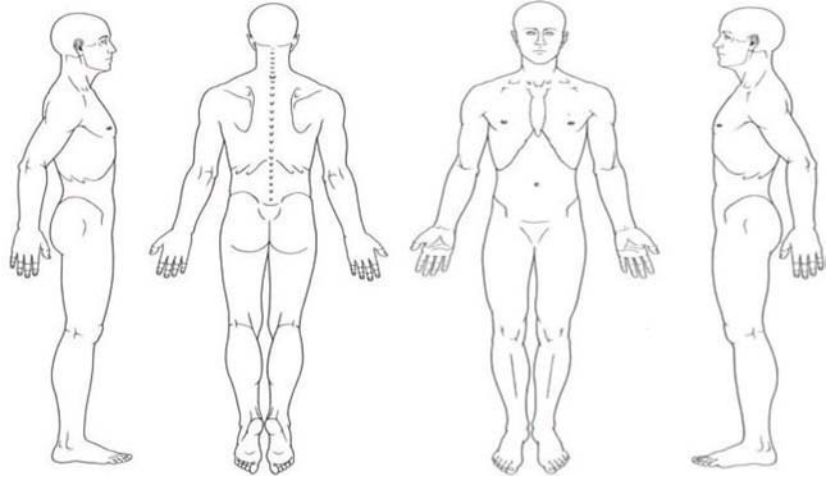
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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: _____
- ② MRI date: _____
- ③ CT Scan 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 _____



2217 Vine Street suite 102 Hudson WI 54016 (715)386-7690 Fax (715)386-7719
507 Cherry Lane Roberts WI 54023 (715)749-4010 (715)749-4015
McCabeChiropractic.com

Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life as well as what you would like to move toward. You may also find your ideas about who you are and your true health expanding as you take your first step with us on your journey toward new levels of health, wellness and wholeness. Here we go!

Personal Information...

Today's Date ___/___/___ Name _____ Birth Date ___/___/___

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____

Number & Street

City

State

Zip

Email Address _____ SSN _____

Single Married Partnered Widowed Divorced

Spouse's Name _____

of Kids ___ How many at home? ___ Names & ages: _____



Employer : _____ Self-employed?

What kind of work do you do? _____

Do you have a primary healthcare advisor? Yes No What type? MD DO Other _____

Have you ever been to a chiropractor before? Yes No Approximate date of last visit ___/___/___

Dr.'s Name/City/State: _____ Good results? Yes No

Have you ever been told you have any problems/defects in your spine or nerve system? Yes No

If yes, what? _____

Please check if you are here for any of the following: Motor Vehicle Injury Work Injury Other Injury

Whom may we thank for referring you to our center? _____

Let's Find Out Why You're Here...

What is the main reason for your visit today? _____

Any other specific concerns? _____

And How You Got to Where You Are Now...



Are there any specific physical, chemical or emotional stresses you are aware of that your mother endured while she was pregnant with you? Yes No

Please explain _____

I was born In a Hospital At Home Any complications with your birth? Yes No

Were you generally healthy and happy during your early childhood years? Yes No

Any specific physical, chemical or emotional stresses you wish to share from your early childhood?

Were you generally healthy and happy during your teen/early adult years? Yes No

Any specific physical, chemical or emotional stresses you wish to share from your teen/early adult years?

Are you/have you been generally healthy and happy during your adult years? Yes No

Any specific physical, chemical or emotional stresses you wish to share from your adult years?

Please list any specific health challenges you have overcome in your life _____

Please list any specific health problems from your family's history that you believe are significant to you

Which Direction Are You Headed?

Currently my physical health is Excellent Good Fair Poor
And I feel it's Improving Staying the Same Getting Worse Up & Down

Currently my mental health is Excellent Good Fair Poor
And I feel it's Improving Staying the Same Getting Worse Up & Down

Currently my emotional health is Excellent Good Fair Poor
And I feel it's Improving Staying the Same Getting Worse Up & Down

Currently my social well being is Excellent Good Fair Poor
And I feel it's Improving Staying the Same Getting Worse Up & Down

Currently my spiritual well being is Excellent Good Fair Poor
And I feel it's Improving Staying the Same Getting Worse Up & Down

Because of My Care Here, I Hope to See Improvement in My...

(1=Very Important To Me 2= Important To Me 3= Not So Important To Me 4= Does Not Apply To Me)

Physical Well Being	1	2	3	4
Mental and Emotional Well Being	1	2	3	4
Ability to Respond Constructively to Stress	1	2	3	4
Overall Level of Joy in Life	1	2	3	4
Making Healthy & Constructive Lifestyle Choices	1	2	3	4
Overall Quality of Life	1	2	3	4

Will you be as happy and healthy as you are today (or BETTER) in 5 years? Yes No Not Sure

If yes, what will you do to make sure you are? _____

If no or not sure, what *could* you do to *start* getting happier & healthier? _____

How committed are you to actively participating in moving yourself toward greater levels of happiness, peace, excitement, health, wellness and wholeness? (Circle your answer)

Not at all 1 2 3 4 5 6 7 8 9 10 100% Committed



Let's Make Sure We're On the Same Page...

When an individual or family seeks and is accepted into a program of **wellness** or **life-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that you understand both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our life-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows a fuller expression of life energy in their bodies.

So while the natural result of a higher expression of life energy *is* increased **health, wellness** and an **overall expansion of your well being**, we will not diagnose, treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek **additional** help from a symptom, illness, and disease orientated professional if you feel that our wellness-based approach will not be sufficient in progressively raising you to the levels of health, wellness and wholeness you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. McCabe to continue with my child's and/or my (circle one) initial consultation and assessment. I also agree to return at a later date to attend an orientation and allow Dr. McCabe to report his findings and recommendations to me immediately following the orientation. By agreeing to this, I am in no way obligated to follow the advice given to me in the orientation and report of findings.

Signed _____ Date ____/____/____

Consent To X-ray

I, _____, do hereby give my consent to allow McCabe Family Chiropractic or McCabe Chiropractic and Wellness Center and its representatives to take x-rays as deemed appropriate by the examining doctor. I also declare to the best of my knowledge that I am not pregnant.

Patient Signature: _____ Date: _____



