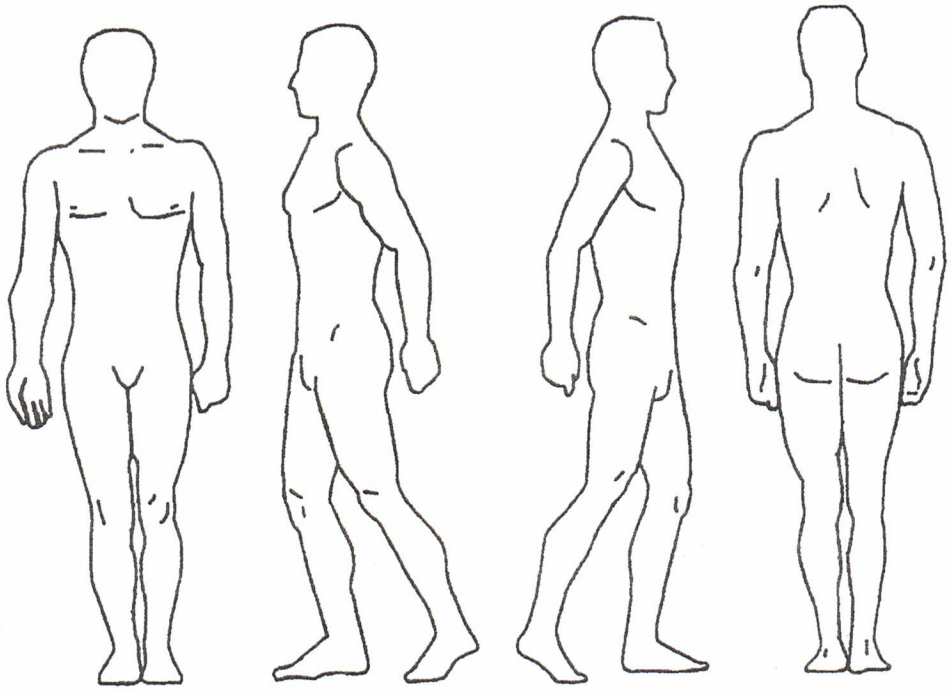
PATIENT HEALTH QUESTIONNAIRE

Chief Complaint - please list how and when symptoms began: _____

_____

My symptoms are currently: **GETTING BETTER** **ABOUT THE SAME** **GETTING WORSE**

Please shade the area(s) where you feel symptoms



What is the frequency of your pain?

Constantly Occassionally

Frequently Intermittently

What describes the nature of your symptoms?

Sharp Shooting

Dull ache Burning

Numb Tingling

On the scale below, please circle the number that best represents the severity of your pain.

Average for the past 48 hours

NO PAIN 0 1 2 3 4 5 6 7 8 9 10

Best for the last 48 hours

NO PAIN 0 1 2 3 4 5 6 7 8 9 10

Worst for the last 48 hours

NO PAIN 0 1 2 3 4 5 6 7 8 9 10

Aggravating Factors: STANDING SITTING LAYING DOWN WALKING BENDING

Easing Factors: STANDING SITTING LAYING DOWN WALKING BENDING

What activities are most limited:_____

Patient/Guardian Initials. _____