PHQ (W/O PAT INFO)

Patient Name:		Date of Birth:		Date of Visit:	

General Information

Preferred language (spoken & written)	
Race	
Ethnicity	
What is your occupation?	
What is your employment status?	☐ Part Time ☐ Full Time ☐ Sick Leave ☐ Unemployed ☐ Retired ☐ Temp Disability ☐ Perm Disability
Do you use tobacco?	○ Current Every Day Smoker ○ Occasional Smoker ○ Former Smoker ○ Never Smoked ○ Unknown
Do you consume alcohol?	○ Never ○ Rare ○ Occasional ○ Other ____ If yes, how often? ____
Have you ever been treated for substance abuse?	○ Yes ○ No
Severe accidents or trauma dates	
Are you pregnant?	☑ No ☐ Yes Due Date ____

Current Issue / Ailment

What is your chief problem or symptom?	
What caused the problem or symptom to occur?	
When did the problem or symptom begin? (Date of injury)	
Have you seen another doctor for this problem?	○ No ○ Yes
What tests/procedures have been performed?	
Have you had this problem or symptom in the past?	○ No ○ Yes
Have you tried any other treatments for this?	○ No ○ Yes
Is the problem or symptom getting worse?	○ Not worse ○ Getting worse ○ Staying same

Pain Evaluation

Describe Your Pain (check all that apply)

Quality of Pain:	Pattern of Pain:	Cause of Pain:	Onset of Pain:
☐ Constant	☐ While Resting	☐ Traumatic ____	☐ Sudden
☐ Intermittent	☐ Daily	☐ Chronic ____	☐ Gradual
☐ Recurring	☐ During Exercise	☐ Post Surgical	
☐ Stabbing	☐ Nightly	☐ Work Related	
☐ Dull Ache	☐ Other ____	☐ Motor Vehicle	
☐ Sharp		☐ School Sports	
☐ Deep Ache		☐ Unknown	
☐ Throbbing		☐ Other ____	
☐ Tingling			

On a scale of 1 to 10, how would you rate your pain or discomfort level? (1=Mild, 10 = Intense)	
How much has pain interfered with your normal work (including both work outside and housework)?	☐ Not at all ☐ A little bit ☐ Moderately ☐ Extremely
In general, how would you describe your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What, if anything, gives you relief?	
What irritates it or makes it worse?	

Allergies

☐ **None (medications, latex, iodine, etc.)**

Medications

☐ **None**

Surgical History

☐ **None**

Surgical Procedure #1	Date of Surgery #1	Surgical Procedure #2	Date of Surgery #2
Surgical Procedure #3	**Date of Surgery #3**	**Surgical Procedure #4**	**Date of Surgery #4**

Medical History

☐ **None**

Current or past ailments/conditions (select all that apply)

☐ Arthritis / Gout	☐ Hepatitis C	☐ HIV / AIDS	☐ Female Disorders
☐ Eye Pain / Strain	☐ Difficulty Swallowing	☐ Neuropathy	☐ Emphysema / COPD
☐ Jaw Pain	☐ Irregular Heartbeat	☐ Groin / Rectal Pain	☐ Headaches
☐ Gall Stones	☐ Wrist/Hand Pain	☐ Digestive Problems	☐ Blurred Vision
☐ Shortness of Breath	☐ Diabetes	☐ High Cholesterol Level	☐ Heart Disease / Attack
☐ Shoulder / Elbow Pain	☐ Broken Bones	☐ Ringing in Ears	☐ Cancer
☐ Stomach / Ulcer Pain	☐ Pregnancy	☐ Chronic Fatigue	☐ Mid / Low Back Pain
☐ Skin Problems	☐ Seizures	☐ Chest Pain / SOB	☐ Foot / Ankle Pain
☐ Depression / Anxiety	☐ Neck Pain / Spasms	☐ Asthma / Bronchitis	☐ Urinary Problems
☐ Dizziness	☐ Thyroid Problems	☐ Hip / Knee / Leg Pain	☐ Irregular Bowels

If you feel it's necessary, expand on selections above

Family History

☐ **None**

Relation to Patient	Illness	Comments