Wake Spine & Pain Specialists
Patient Health Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Please mark yes or no for the following symptoms you have experienced in the past year.

	Yes	No
General:		
weight gain	O	O
weight loss	O	O
fever	O	O
Hematologic/Lymph:		
bruising	O	O
rash	O	O
Head/Eyes:		
vision changes	O	O
glaucoma	O	O
Ear/Nose/Throat:		
infections	O	O
bleeding gums	O	O
Neuro/psych:		
headaches	O	O
seizures	O	O
dizziness	O	O
syncope	O	O
paralysis	O	O
memory loss	O	O
disorientation	O	O
hallucinations	O	O
anxiety	O	O
Endocrine:		
frequent thirst	O	O
frequent urination	O	O
Cardiovascular:		
chest pain	O	O
palpitations	O	O

	Yes	No
Respiratory:		
cough	O	O
shortness of breath	O	O
Gastrointestinal:		
nausea	O	O
constipation	O	O
diarrhea	O	O
reflux	O	O
Urinary:		
incontinence	O	O
hesitancy	O	O
Musculoskeletal:		
weakness	O	O
joint pain	O	O
Ambulation Aids:		
cane	O	O
walker	O	O
wheelchair	O	O

Medical History: please mark all that apply:

Diabetes	O	O
Hypertension	O	O
Cancer	O	O
Arthritis	O	O
CHF	O	O
COPD	O	O

Family History – please mark all that apply:

Mother:	O Heart Disease	O Diabetes	O Cancer
Father:	O Heart Disease	O Diabetes	O Cancer
Grandparents:	O Heart Disease	O Diabetes	O Cancer
Siblings:	O Heart Disease	O Diabetes	O Cancer

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Marital Status: O married O single O widowed

Tobacco use: O yes O no
Packs per day: O 1 or less O 1-2 pks O more than 2 pks
Prior tobacco use: O yes O no
How long ago did you quit? O less than 1 yr O 1-5 yrs O 6-10 yrs O 10+ yrs

Caffeine: O yes O no
O 8-16 oz daily O 17-24 oz daily O more than 24 oz daily

Alcohol: O yes O no
If yes, how frequently do you drink? O daily O weekly O monthly O a couple of times a year
How many drinks? O 2-3 O 4-8 O more than 10 O more than 20

Describe your pain:

What makes your pain worse?
O lying down O sitting O standing O driving O lifting O walking
O stairs O weather change O position of limb O none

What relieves your pain?
O analgesics O heat O cold O rest O TENS O biofeedback O position change
O elevation of limbs O massage O physical therapy O chiropractor O acupuncture O none

What type of pain are you experiencing?
O burning O stinging O aching O tender O stabbing O numbness
O tingling O spasm O coolness O throbbing O none

What symptoms are associated with your pain?
O sleep alteration O depression O anxiety O antisocial O PTSD
O ADHD O substance abuse O atrophy O walking aid
O bowel/bladder incontinence O none

Rate your pain on a scale of 0 to 10 (with 0 being none and 10 being the worst imaginable).
Now: O zero O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
Least: O zero O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
Worst: O zero O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Which modalities have you tried and how successful were they?
Physical Therapy - O helped significantly O did not help
TENS - O helped significantly O did not help