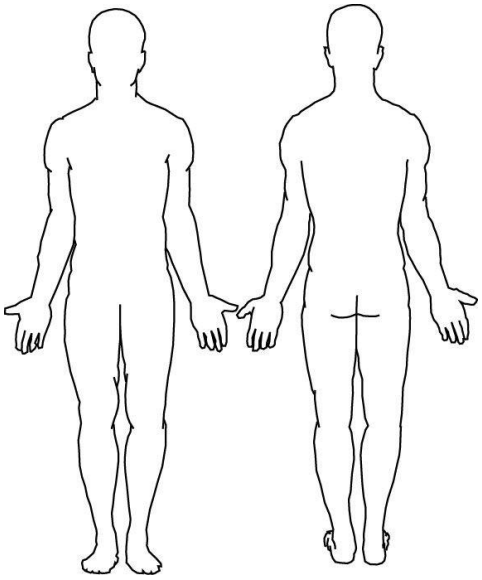
Patient Health Questionnaire

Indicate where you have pain by circling the area(s) on the body map image below.

FRONT **BACK**



Please circle your pain level on the scale below.

| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
0 1 2 3 4 5 6 7 8 9 10

NO PAIN — WORST POSSIBLE PAIN

What increases your pain? _____

What decreases your pain? _____

Do you have night pain? YES NO

Have you consulted with a doctor? YES NO

Circle any health conditions you have been diagnosed with.

Diabetes	Heart Condition	Pace Maker	Pregnant	Arthritis
Headaches	Respiratory	Depression	Anxiety	Stress
High Blood Pressure	Cancer	Surgery	Other_____	

List any medications you are taking as a result of your injury. _____

_____

_____

Has your body weight increased/decreased in the past 5 years? YES _____ lbs NO

Have you had an x-ray? YES NO

Have you had an ultrasound? YES NO

Have you had an MRI? YES NO

Would you be interested in meeting with a Certified Professional Coach to help meet your goals? YES NO

Would you be interested in working with a personal trainer to improve your health? YES NO

Circle any additional programs you may like information on.

Acupuncture	Weight Loss Program	Certified Professional Coaching
Coping with Anxiety/Depression		Smoking Cessation

Patient Signature _____ Date _____