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 _____

_____

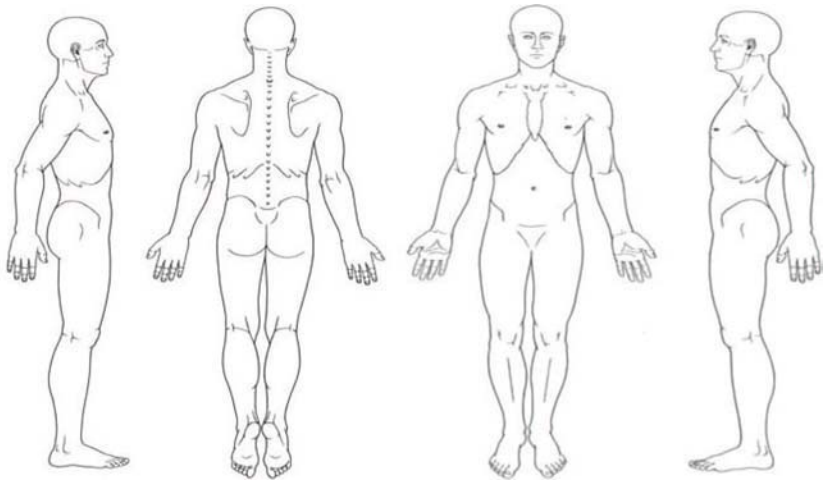
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb 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 ⓪ 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

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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:* _____ ③ CT Scan *date:* _____
② MRI *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*** _____

Lower Extremity Functional Scale (LEFS)

"The LEFS is easy to administer and score and is applicable to a wide range of disability levels and conditions and all lower-extremity sites."[1] It is a functional measure that, "… can be used by clinicians as a measure of patients' initial function, ongoing progress, and outcome as well as to set functional goals."[1] It is a self-report condition-specific measure that has been proven to yield reliable and valid measurements. "…the LEFS is more interpretable [than the SF-36 physical function subscale]…for determining minimally clinically important score changes and is a sufficient measure of reliability, variability, and sensitivity to change, at a level that is commensurate with utilization at an individual patient level."[1]

Scoring

LEFS is scored via summation of all responses (one answer per section) and compared to a total possible score of 80. **(Score = X/80)**

The LEFS **raw score is the final score** and should be compared to the total possible score of 80 as a reference.

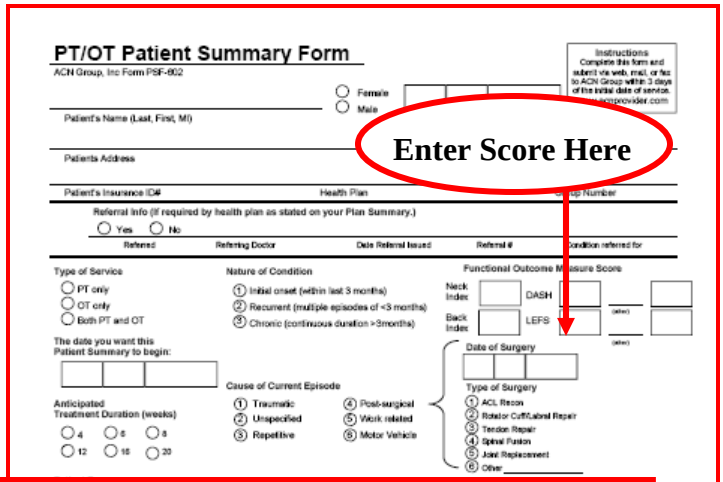
Error +/- 5 points; an observed score is within 5 points of a patients "true" score.

Minimum detectable change (MDC): 9 points; change of more than 9 points on the LEFS represents a true change.

Minimum clinically important difference (MCID): 9 points; "Clinicians can be reasonably confident that a change of greater than 9 points is… a clinically meaningful functional change."[1]

[1] Binkley JA, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): Scale Development, Measurement Properties, and Clinical Application. Physical Therapy (1999) 79, 371-383.

ACN Group requests an outcome measure be completed on the initial submission **(baseline)**, requests for additional services **(response to treatment)**, and at patient discharge **(effectiveness of intervention)**.



THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	(1)	2	3	4
2	Your usual hobbies, re creational or sporting activities.	(0)	1	2	3	4
3	Getting into or out of the bath.	0	(1)	2	3	4
4	Walking between rooms.	0	1	(2)	3	4
5	Putting on your shoes or socks.	0	1	2	(3)	4
6	Squatting.	0	(1)	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	(3)	4
8	Performing light activities around your home.	0	1	(2)	3	4
9	Performing heavy activities around your home.	0	(1)	2	3	4
10	Getting into or out of a car.	0	1	(2)	3	4
11	Walking 2 blocks.	0	1	(2)	3	4
12	Walking a mile.	0	(1)	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	(1)	2	3	4
14	Standing for 1 hour.	0	1	(2)	3	4
15	Sitting for 1 hour.	0	1	2	(3)	4
16	Running on even ground.	(0)	1	2	3	4
17	Running on uneven ground.	(0)	1	2	3	4
18	Making sharp turns while running fast.	(0)	1	2	3	4
19	Hopping.	(0)	1	2	3	4
20	Rolling over in bed.	0	1	2	3	(4)
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: (29) / 80**

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

Score = (*sum of responses*/80) = (29/80)

* For ACN Group forms please enter the sum of responses as the "score" on the Patient Summary Form (i.e. 29)

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3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
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Please submit the sum of responses to ACN.

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