PATIENT HEALTH QUESTIONNAIRE- PLEASE COMPLETELY FILL OUT THIS FORM!

Name:____ Date of birth: ___________________________

Please describe your current complaint or limitation:____

Who is your primary care physician? (PCP):____

Please describe how your problem began/started:____Date if possible: ______________

Please list all current medications: ____

Are you allergic to any medications? If so, please list them:____

Did you have surgery: (Please circle) YES NO Date:_______/_______/_______

Do you have a pacemaker? (Please circle) YES NO

CONFIDENTIAL

Please circle if you have had any of the following symptoms/conditions in the last year:

Heart palpitations	Loss of balance	Bowel or bladder problems
Chest Pain	Difficulty Walking	Fever/chills/sweat
Cough	Joint pain or swelling	Headaches
Shortness of breath	Night pain	Hearing problems
Dizziness	Difficulty Sleeping	Vision problems
Coordination problems	Loss of appetite	Pregnant
Weakness in arms or legs	Nausea/Vomiting	Highly Stressed
Sharp Pain	Numbness	Tingling
Dull Pain/Ache	Shooting	Allergies
Throbbing	Burning	Cancer:________________________

- Indicate the intensity of your pain **at rest**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
- Indicate the intensity of your pain **with movement:** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
- Since this condition began your symptoms have: (circle) Decreased Not Changed Increased
- Your Symptoms are worse in: (circle) morning afternoon night increased during the day same all day
- In the past have you been treated for the same problem? (circle) YES NO
- If yes, who did you see for that condition? (circle) MD PT OT Chiropractor Other:____________________
- When and what treatment did you receive:____

Occupation____ Has your work status changed because of this condition: YES NO

Have you had any tests done for THIS injury? If so, please list results and dates:

X-Ray:____ EMG:____

MRI:____ CAT Scan:____

With Whom do you live?____

Do you use an assistive device for mobility?_______________, if so, what?____

Do you smoke?_________________________ Do you drink alcohol? ___________________________

How many days a week do you exercise?______________________

How would you rate your health? (Circle) Excellent Good Fair Poor

Is this injury due to an auto accident? (Circle) Yes No If yes, date of auto accident:____________________________________

Is this injury due to a workman's compensation claim? (Circle) Yes No If yes, date of accident at work:________________________

Is your primary Insurance Medicare or any replacement plan for Medicare? (Circle) Yes No

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Insurance Carrier (non-Medicare only):____

Do you have a pacemaker? (Circle) YES NO

If you have ever had a listed condition in the past, please circle it in the PAST column. If you are presently troubled by a particular condition, circle it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST PRESENT High Blood Pressure (401.9)
PAST PRESENT Angina (413.9)
PAST PRESENT Heart Attack (410.9)
PAST PRESENT Stroke (436.0)
PAST PRESENT Asthma (493.9)
PAST PRESENT HIV/AIDS (042.0)
PAST PRESENT Cancer (199.1) Location(s):________________ Date:________________
PAST PRESENT Tumor (229.9)
PAST PRESENT Systemic Lupus (710.0)
PAST PRESENT Hepatitis (573.3)
PAST PRESENT Epilepsy (549.5)
PAST PRESENT Diabetes (250.0)
PAST PRESENT Arthritis (714.0)

What are your physical therapy goals:____

PATIENT SIGNATURE:____ DATE:__________________________