PATIENT HEALTH QUESTIONNAIRE- PLEASE COMPLETELY FILL OUT THIS FORM!

Name:_____ Date of birth: _____

Please describe your current complaint or limitation:_____

Please describe how your problem began/started:_____Date if possible: _____

Please list all current medications: _____

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

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	Constant (76-100%)
Throbbing	Burning	Frequent (51-75%)
Occasional (26-50%)	Intermittent (25% or less)	Allergies

- 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

Insurance Carrier (non-Medicare only):_____

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:_____