

## PATIENT HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Leisure Activities: \_\_\_\_\_

Did you have surgery: Yes: \_\_\_ No: \_\_\_ Date: \_\_\_\_\_ Type of Surgery: \_\_\_\_\_

Describe your Current Complaint or Problem: \_\_\_\_\_

Describe how your problem began: \_\_\_\_\_

When did your problem begin: \_\_\_\_\_ Specific Date if possible: \_\_\_\_\_

Your Symptoms are worse in: \_\_\_ morning \_\_\_ afternoon \_\_\_ night \_\_\_ increased during the day \_\_\_ same all day

Are your symptoms (check one): \_\_\_ Getting worse \_\_\_ The same \_\_\_ Improving

I have difficulty with \_\_\_ sleep \_\_\_ dressing \_\_\_ work \_\_\_ driving \_\_\_ walking \_\_\_ standing

\_\_\_ rising from a chair \_\_\_ bending \_\_\_ lifting \_\_\_ Playing sports \_\_\_ Running \_\_\_ Calisthenics

In the past have you been treated for the same problem? \_\_\_ Yes \_\_\_ No, If yes, who did you see for this condition?:

\_\_\_\_\_ When and what treatment did you receive?: \_\_\_\_\_

Please check off any of the following whose care you are under: Medical Doctor (MD): \_\_\_ Osteopath (DO): \_\_\_

Dentist: \_\_\_ Chiropractor: \_\_\_ Psychologist/Psychiatrist: \_\_\_ Physical Therapist: \_\_\_ Other: \_\_\_\_\_

**Have you EVER or any immediate family member been diagnosed as having the following conditions:**

	SELF		FAMILY			SELF	
High Blood Pressure	YES	NO	YES	NO	Angina/Chest Pain	YES	NO
Diabetes	YES	NO	YES	NO	Seizures/headaches	YES	NO
Cancer	YES	NO	YES	NO	Balance problems	YES	NO
Thyroid	YES	NO	YES	NO	Allergies/Asthma	YES	NO
Heart Disease	YES	NO	YES	NO	Emphysema/bronchitis	YES	NO
Rheumatoid Arthritis	YES	NO	YES	NO	Fibromyalgia	YES	NO
Other arthritic conditions	YES	NO	YES	NO	Chronic fatigue	YES	NO
Skin Problems	YES	NO	YES	NO	Anemia	YES	NO
Osteoporosis	YES	NO	YES	NO	Stroke	YES	NO
Kidney Disease	YES	NO	YES	NO	Incontinence	YES	NO
Multiple Sclerosis	YES	NO	YES	NO	Pregnancy	YES	NO

OTHER: \_\_\_\_\_

**During the past 3 months have you had the following:**

Any change in your health	YES	NO	Dizziness	YES	NO
Fever/chills/sweats	YES	NO	Numbness/tingling	YES	NO
Nausea/Vomiting	YES	NO	Difficulty swallowing	YES	NO
Change in appetite	YES	NO	Urinary Tract Infection	YES	NO
Unexplained weight change	YES	NO	Upper respiratory Infection	YES	NO
Changes in bladder/bowel	YES	NO	Stress	YES	NO
Shortness of breath	YES	NO	Depression	YES	NO

Date of last medical examination: \_\_\_\_\_ Do you have recent Lab results? \_\_\_ Yes \_\_\_ No

Have you had any medical tests? \_\_\_ Yes \_\_\_ No, If Yes, please describe: \_\_\_\_\_

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? \_\_\_ Yes \_\_\_ No

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason:

DATE	REASON	DATE	REASON
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

Please describe any significant injuries for which you have been treated including fractures, dislocations, sprains and approximate date:

DATE	INJURY	DATE	INJURY
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

Please list any prescription medication you are currently taking: (Pills, Injections, and/or skin patches):

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

**Which of the following OVER-THE-COUNTER MEDICATIONS have you taken in the last week?**

Aspirin	YES	NO	Decongestants	YES	NO
Tylenol	YES	NO	Laxatives	YES	NO
Aleve	YES	NO	Advil/Motrin/Ibuprophen	YES	NO
Antacid	YES	NO	Antihistamines	YES	NO
Vitamins/mineral supplements				YES	NO

How much caffeinated coffee or caffeine containing beverages do you drink per day?: \_\_\_\_\_ How many packs of cigarettes do you smoke per day?: \_\_\_\_\_ How many days per week do you drink alcohol?: \_\_\_\_\_ If one drink equals one beer or glass of wine, how much do you drink at an average sitting?: \_\_\_\_\_

My goals for physical therapy are (what do I expect from therapy): \_\_\_\_\_

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY:**

VITAL SIGNS:

\_\_\_\_\_  
Height

\_\_\_\_\_  
Weight

\_\_\_\_\_  
Blood Pressure

\_\_\_\_\_  
Heart Rate

\_\_\_\_\_  
Temperature

**Please create a Chart of Your Current Symptoms:**

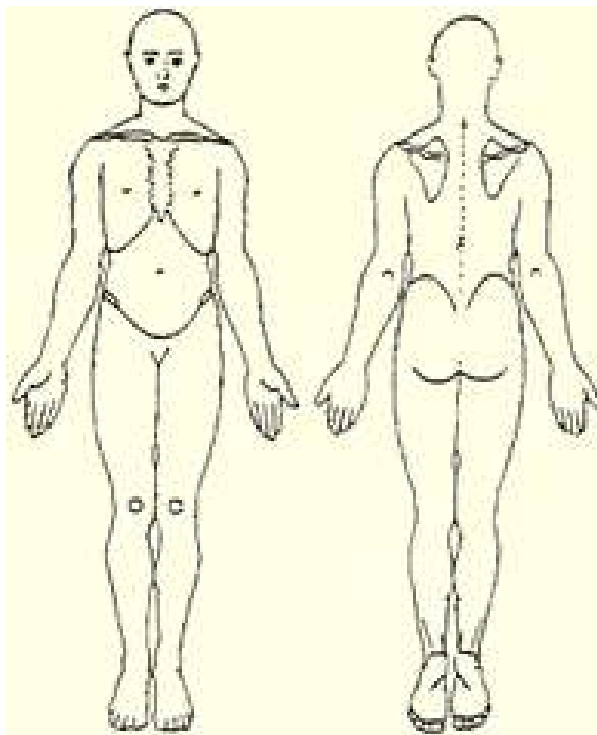
Please complete the following regarding your present condition:

Prescribe the Nature of your pain:

- |              |             |             |
|--------------|-------------|-------------|
| 1 Sharp Pain | 5 Throbbing | 9 Heavy     |
| 2 Shooting   | 6 Tingling  | 10 Tight    |
| 3 Burning    | 7 Numb      | 11 Pulling  |
| 4 Dull       | 8 Ache      | 12 Stabbing |

Please describe the pattern or frequency of your pain:

- |                                 |                      |
|---------------------------------|----------------------|
| A Constant (100%)               | E Variable (changes) |
| B Frequent (>once per day)      | F Intermittent       |
| C Occasionally (once per day)   | G Previously         |
| D Infrequently (<once per week) |                      |



**PAIN SCALE:**

**Circle Your pain at rest and with activity/movement**

**0-NO PAIN**

**1- VERY WEAK PAIN:** at times, you forget about it

**2- WEAK PAIN:** Tolerable, You can go about your daily activities and hardly notice the pain.

**3- NOTICEABLE PAIN:** You can do your activities, but you know the pain is there.

**4- SOMEWHAT STRONGER PAIN:** It definitely hurts, you might want to take a pill to get through the day.

**5- STRONG PAIN:** It slows you down, you think about taking the day off or seeing your doctor.

**6- STRONGER PAIN:** You show it on your face and in your actions. You have to get some relief.

**7- VERY STRONG PAIN:** It catches your breath. You may have tears in your eyes. You must lie down.

**8- VERY, VERY STRONG PAIN:** You may cry out or moan. You are cannot to do any work and unable to help your self.

**9- NEAR EMERGENCY PAIN:** You only think about much it hurts. You sweat, cry, and moan. Your heart pounds.

**10- EMERGENCY PAIN:** You need the hospital. You may scream. The world is a blur of pain. The pain is unbearable.