PATIENT HEALTH QUESTIONAIRE

NAME:_____ DATE_____

1. Please Describe your Current Complaint or Limitation: _____

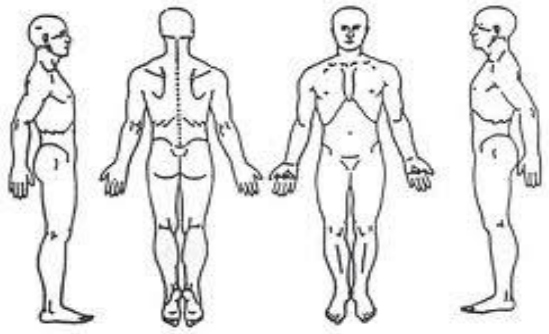
_____

2. What is your goal for physical therapy: _____

_____

a. Please describe the nature of your pain (check all that apply):

__ Sharp Pain __ Dull (Pain) Ache __Throbbing __Numbness __Shooting __Burning __Tingling
__ Constant (76-100%) __ Frequent (51-75%) __ Occasional (26-50%) __ Intermittent (25% or less)



MARK ON THIS PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

b. Indicate the intensity of tour 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
c. What movement causes the pain to increase:_____
d. Since the condition began your symptoms have: ___ decreased ___ not changed ___ increased
e. Your symptoms are worse in: ___morning ___afternoon ___night ___increased during the day ___same all day

3. When did your problem begin: _____days ago _____months ago _____years ago Date(if possible)_____
Describe how your problem began:_____
_____
Did you have surgery? ___Yes or ___No Date of Surgery:_____

4. In the past have you been treated for the same problem? ___Yes or ___No
If yes, who have you seen for that condition? __MD __Physical Therapist __Occupational Therapist __Chiropractor __Other____
When and what treatment did you receive?_____

5. What makes your problem better? __Nothing __Lying down __Standing __Sitting __Movement/Exercise __Inactivity
6. What makes your problem worse? __Nothing __Lying down __Standing __Sitting __Movement/Exercise __Inactivity

7. Occupation_____ __FT or __PT Has your work status changed because of this condition? __Yes __No
8. What is your current work status? __FT, no restrictions __PT, no restrictions __Unemployed __Off work due to restrictions
__FT, with restrictions __PT, with restrictions __FT Student __FT Homemaker __Retired

Present Weight: _____ Height: ___feet ___inches

PLEASE TURN OVER

If you have ever had a listed condition in the past, please check in the PAST column. If you are presently troubled by a particular condition, check 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)
___	___	Angina (413.9)
___	___	Heart Attack (410.9)
___	___	Stroke (436)
___	___	Asthma (493.9)
___	___	HIV/AIDS (042)
___	___	Cancer (199.1) Location:_____ Date:_____
___	___	Tumor (229.9)
___	___	Systemic Lupus (710.0)
___	___	Hepatitis (573.3)
___	___	Epilepsy (349.5)
___	___	Diabetes (250.0)
___	___	Rheumatoid Arthritis (714.0)
___	___	Pregnancy
___	___	Other_____
___	___	Tobacco (305.1) #packs/day_____
___	___	Drug or Alcohol Dependence (303.9)
___	___	Coffee/Tea/Caffeine drinks: Cups/cans per day_____

FAMILY HISTORY

Please check if any blood relative has had the following:

___Obesity	relation_____	___Arthritis	relation_____
___Diabetes	relation_____	___Heart Disease	relation_____
___High Blood Pressure	relation_____	___Stroke	relation_____
___Cancer	relation_____	___Tuberculosis	relation_____
___Kidney Disease	relation_____	___Other	relation_____

Please list all **medications/prescriptions** currently taking:_____

_____

_____

Please list all **allergies**: _____

_____

HOSPITALIZATIONS/SURGERIES

Month/Year	Hospital	Reason for hospitalization

I certify that the above information is correct to the best of my knowledge. I will not hold SPAGNOLI PHYSICAL THERAPY responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature Date

_____

Reviewed by (PT) Date