** PATIENT HEALTH QUESTIONAIRE**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_

1. Please Describe your Current Complaint or Limitation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

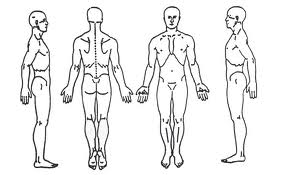
2. What is your goal for physical therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**a**. List one activity you are unable to do that you want to do again: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. 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

c. 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

d. What movement causes the pain to increase:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Since the condition began your symptoms have: \_\_\_ decreased \_\_\_ not changed \_\_\_ increased

f. 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**. Have you had this same or similar problem before? \_\_\_yes \_\_\_\_ 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**. How optimistic are you that you’ll get better (circle one): Not at all Mildly Fairly Very Extremely

**6**. What are some obstacles to you getting better? Financial Family Support Time Motivation Age Transportation N/A

7. What makes your problem better? \_\_Nothing \_\_Lying down \_\_Standing \_\_Sitting \_\_Movement/Exercise \_\_Inactivity

8. What makes your problem worse? \_\_Nothing \_\_Lying down \_\_Standing \_\_Sitting \_\_Movement/Exercise \_\_Inactivity

9. Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_FT or \_\_PT Has your work status changed because of this condition? \_\_Yes \_\_No

10. 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

**11**. Are you willing and able to enter into an agreement with your therapist to meet your goals? Yes No

**Present Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_feet \_\_\_inches**

**PLEASE TURN OVER**

Please indicate if you have had or currently have any of the following conditions. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

**YES**  **NO**

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

\_\_\_ \_\_\_ High Cholesterol

\_\_\_ \_\_\_ Angina

\_\_\_ \_\_\_ Anxiety

\_\_\_ \_\_\_ ADD/ADHD

\_\_\_ \_\_\_ Depression

\_\_\_ \_\_\_ Heart Attack

\_\_\_ \_\_\_ Stroke

\_\_\_ \_\_\_ Osteoporosis/Osteopenia

\_\_\_ \_\_\_ Asthma

\_\_\_ \_\_\_ HIV/AIDS

\_\_\_ \_\_\_ Systemic Lupus

\_\_\_ \_\_\_ Hepatitis

\_\_\_ \_\_\_ Epilepsy

\_\_\_ \_\_\_ Diabetes

\_\_\_ \_\_\_ Rheumatoid Arthritis

\_\_\_ \_\_\_ Cancer Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Currently undergoing Chemotherapy

\_\_\_ \_\_\_ Currently undergoing Radiation Therapy

\_\_\_ \_\_\_ Pregnancy

\_\_\_ \_\_\_ Stress Incontinence

\_\_\_ \_\_\_ Urge Incontinence

\_\_\_ \_\_\_ Tobacco #packs/day\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Drug or Alcohol Dependence

\_\_\_ \_\_\_ Coffee/Tea/Caffeine drinks: Cups/cans per day\_\_\_\_\_

\_\_\_ \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ History of falling \_\_\_\_# of times you have fell in past year Injury sustained\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 **Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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