PATIENT HEALTH QUESTIONNAIRE

NAME: _____ DATE:_____

Email:_____

1. Please Describe your Current Complaint or Limitation:_____

_____

2. How did the injury occur:_____

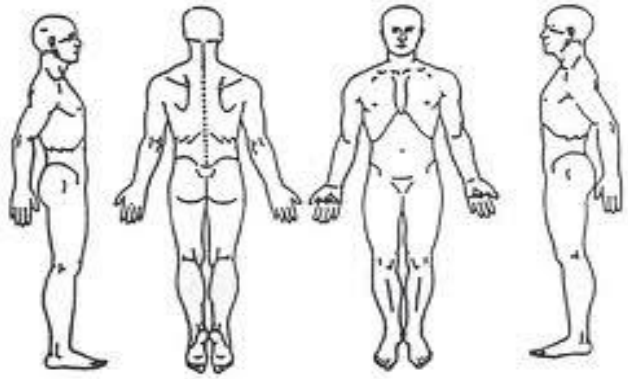
3. Did you have surgery? Yes ___ or No ___ Date of Surgery: _____

4. What is your goal for physical therapy:_____

5. List one activity you are unable to do that you want to do again:_____

6. 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

7. 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

8. What movement/activity causes the pain to increase:_____

9. Have you had this same or similar problem before? Yes___ No___

a. If yes, who have you seen for that condition? _____

b. When and what treatment did you receive? _____

10. Occupation_____ Has your work status changed because of this condition? Yes___ No___

11. Are you willing and able to enter into an agreement with your therapist to meet your goals? Yes___ No___

12. History of falling? Yes___ No___ # of times you have fell in past year___ Injury sustained_____

13. Present Weight: _____ Height: ___feet ___inches

Please visit this website for more information regarding BMI and healthy weight: https://www.cdc.gov/healthyweight

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.

___ High Blood Pressure
___ Low Blood Pressure
___ Angina
___ Anxiety
___ ADD/ADHD
___ Depression
___ Heart Attack
___ Pacemaker
___ Aneurysm
___ Stroke
___ Shortness of Breath
___ Chest Pain
___ Osteoporosis/Osteopenia
___ Asthma
___ HIV/AIDS
___ Systemic Lupus
___ Hepatitis
___ Epilepsy
___ Diabetes
___ Rheumatoid Arthritis
___ Cancer Location: _____ Onset Date:_____
___ Currently undergoing Radiation Therapy
___ Currently Undergoing Chemotherapy

___ Head/Neck Injury
___ Arm/Elbow Injury
___ Upper Back Injury
___ Low Back Injury
___ Hip/Knee Injury
___ Foot/Ankle Injury

___ Pregnancy Due Date:_____
___ Stress Incontinence
___ Urge Incontinence
___ Urinary Frequency
___ Irritable bowel syndrome
___ Constipation

___ Tobacco #packs/day_____
___ Drug or Alcohol Dependence
___ Coffee/Tea/Caffeine drinks:
___ Other_____

Please list all **allergies**:

_____

Family Medical History:_____

HOSPITALIZATIONS/SURGERIES

Month/Year	Hospital	Reason for hospitalization

I certify that the above information is correct to the best of my knowledge. I understand that the questions asked of me are essential to my safety and necessary for Spagnoli Physical Therapist' in developing my treatment plan.

_____

Signature Date

_____

Reviewed by (PT) Date