PATIENT HEALTH QUESTIONNAIRE

Name ____ Date ______/______/________

Describe your current complaint or limitation (i.e. Why are you here today?): ______________________________

____

How and ***When*** did your problem begin? ____

Did you have surgery? ☐ No ☐ Yes Date _____/_____/_____X-ray ◻ No ◻ Yes MRI? ◻ No ◻ Yes Date ____/____/_____

Please list three (3) things that you have problems doing because of your injury/pain: (i.e. putting something on shelf above head):

1. ________________________ 2. ______________________________ 3. ________________________

List any recreational activities or hobbies you have: ____

Intensity of your pain ***at worst:*** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Intensity of your pain ***best:*** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Intensity of your pain ***currently:*** (no pain)0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

☐ Constant (76 – 100%) ☐ Frequent (51 – 75%) ☐ Occasional (26 – 50%) ☐ Intermittent (25% or less)

☐ Sharp Pain ☐ Shooting ☐ Dull Ache

☐ Burning ☐ Tingling ☐ Numbness ☐ Stabbing

Since the condition began your symptoms have: ☐ decreased ◻ increased ◻ not changed

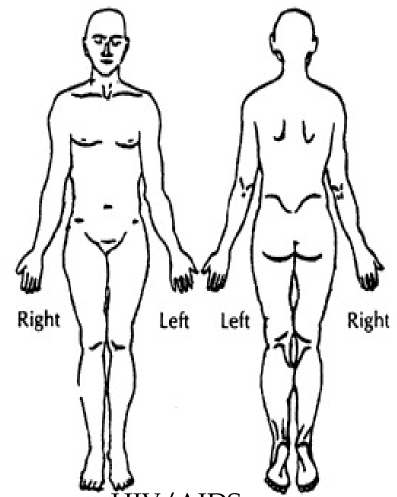
What makes pain worse? _____________ What makes pain better? __________________

Your symptoms are worst in: ◻ a.m. ◻ p.m. ◻ increase during day ◻ same all day

Who have you seen for this problem? ____________ Next Visit Date with MD? ______________

Your Occupation: ______________________________________

Has your work status changed because of this condition? ☐ No ☐ Yes



Please check all that apply for past/present:

◻ High Blood Pressure ◻ High Cholesterol ◻ Angina ◻ Stroke ◻ Asthma ◻ HIV/AIDS

◻ Tumor ◻ Systemic Lupus ◻ Hepatitis ◻ Epilepsy ◻ Diabetes ◻ Rheumatoid Arthritis

◻ Arthritis ◻ Pacemaker ◻ Tobacco packs per day___________ ◻ Cancer please specify_____________

◻ Drug or alcohol dependence ◻ Metal prosthesis/implants_______________________ ◻ other ____________

Have you fallen in the past year? If yes, how many times and did it result in injury? ______________________

What is your main goal in attending physical therapy?____

Hospitalizations/Surgeries:

____

____

All Current Medications: (Please provide a list if you have one)

____

____

____

Patient Signature **Date**