MORIARTY PHYSICAL THERAPY

Patient Health Questionnaire

Name: _____ Date: _____

Referring MD: _____

Current complaint or limitation: _____

Please describe how your problem began:_____

_____

Please tell us when your condition started _____ Specific date if possible_____

Date of Injury/Onset: _____ ☐ Work Related ☐ Auto Accident ☐ School Injury

Occupation: _____ Present work status: _____

Past Medical History - Please check all that are applicable:

☐ High Blood Pressure	☐ Stroke	☐ Hepatitis	☐ Heart Attack
☐ HIV/AIDS	☐ Systemic Lupus	☐ Asthma	☐ Depression
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Pacemaker	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Tuberculosis	☐ Latex Allergy	☐ Currently Pregnant
☐ Osteoarthritis	☐ Angina	☐ Osteoporosis	Other: _____

☐ Cancer - Location(s) and Date(s): _____

Have you had physical therapy in the past for this same problem? ☐ Yes ☐ No

If Yes, who did you see for that condition ☐ MD ☐ Physical Therapist ☐ Occupational Therapist

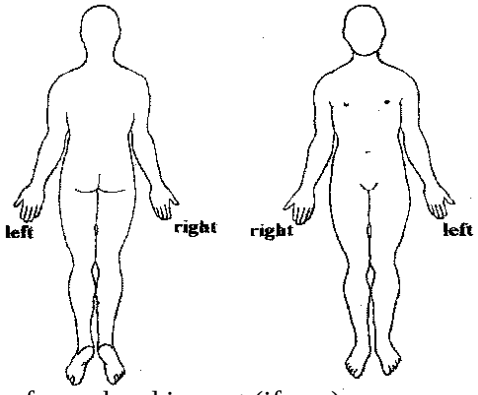
When and what treatment did you receive?_____

Please indicate the intensity of your symptoms at their **WORST**:
(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Please indicate the intensity of your symptoms at its **BEST**:
(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Please check the description of your symptoms (any that apply):

☐ Dull (pain) Ache	☐ Numbness	☐ Constant (76-100%)
☐ Sharp Pain	☐ Shooting	☐ Frequent (51-75%)
☐ Throbbing	☐ Burning	☐ Occasional (26-50%)
☐ Tingling		☐ Intermittent (25% or less)



On the diagram, mark the location(s) of your pain and/or the location(s) of your head impact (if any).

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

Your symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day

Please list any current medications with dosages you are presently taking (including prescription, over-the-counter, herbals, vitamins/minerals/dietary or nutritional supplements).

Medication	Dosage	Hospitalization/Surgical Procedures
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Please see attached copy of medication list provided by the patient. ☐ I am not taking any medication.

Present: Weight_____ Height:_____ feet_____in.

Is there someone specific we may thank for referring you to us? ☐ Yes: _____ ☐ No

Patient or Authorized Representative Signature_____