



Patient Health Questionnaire

Name: _____ Date: _____

Referring MD: _____ Primary Care Physician: _____

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

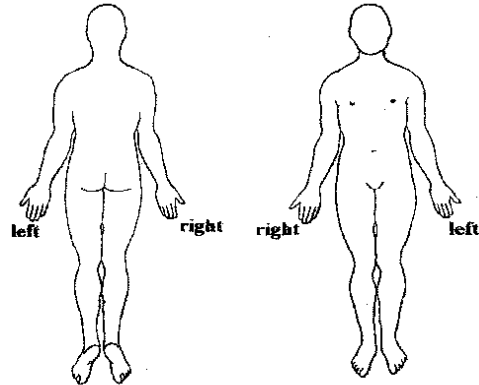
When and what treatment did you receive? _____

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 _____