moriarty
PHYSICAL THERAPY

PATIENT HEALTH QUESTIONNAIRE

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Name: _____ **Date:** _____

Referring MD: _____ **Primary Care Physician:** _____

Current complaint or limitation: _____

How did your problem begin? _____

_____

_____

Please tell us when your condition started:

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 treatment 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 (0 being no intensity, 10 being unbearable)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please indicate the intensity of your symptoms at their BEST (0 being no intensity, 10 being unbearable)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Since this condition began your symptoms have: ☐ Decreased ☐ Not Changed ☐ Increased

When are your symptoms at their worst?

☐ Morning ☐ Afternoon ☐ Night ☐ Increased During the Day ☐ Same all Day

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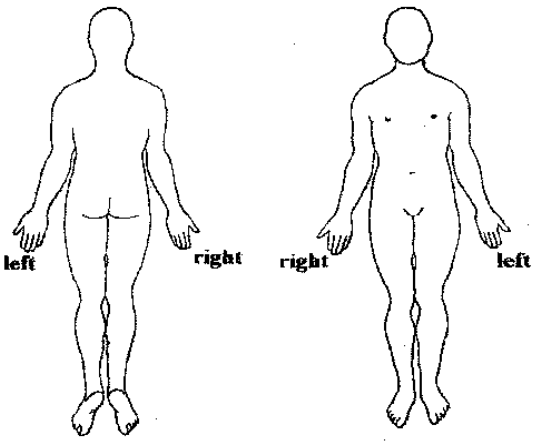
Please check the description and frequency of your symptoms (any that apply)

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

On the diagram, mark the location(s) of your head impact (if any)



BACK **FRONT**

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

☐ Please see attached copy of medication list provided by patient

☐ I am not taking any medications

Hospitalization/Surgical Procedures: _____

_____

Present: Weight _____ Height _____ feet _____ inches

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

Patient or Authorized Representative Signature _____