

PATIENT HEALTH QUESTIONNAIRE

NAME: _____ **Age:** _____ **Date of Birth:** ____/____/____

Please answer the following questions as completely as possible. The answers to this form will help your physical therapist better understand your medical concerns and conditions.

PERSONAL INFORMATION:

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ How did you hear of us? _____

Height: _____ Weight: _____ Right Handed Left Handed Ambidextrous

Occupation: _____ Presently Working: YES NO

Marital Status: _____ # of Children: _____

Have you ever had Physical Therapy for this condition: YES NO If yes, when? _____

Do you engage in any of the following?

Exercise / Sports:	YES	NO	Type / Frequency:	_____
Smoking:	YES	NO	Estimated Use:	_____
Alcohol:	YES	NO	Estimated Use:	_____
Coffee / Caffeine:	YES	NO	Estimated Use:	_____

PRIMARY INSURANCE:

Subscriber's Name: _____ Relation to Insured: _____ DOB: _____

PAIN:

Please complete the following Pain Scales: (0 = no pain, 10 = worst possible pain)

Current Pain: _____ Highest Pain Level: _____ Lowest Pain Level: _____

Describe Pain: ___ Dull ___ Achy ___ Burning ___ Sharp ___ Stabbing/Shooting ___ Numb ___ Tingling ___
Other: _____

Location of your Pain/Injury: _____

MEDICAL HISTORY:

If you check current or past, please comment.

<u>Medical Problem:</u>	<u>Past</u>	<u>Present</u>	<u>Never</u>	<u>Comments</u>
Cardiovascular (Heart Problem, High Blood Pressure, Pacemaker, Cardiac Surgeries, Other)	o	o	o	_____ _____ _____
Pulmonary: (Asthma, Lung Disease, Breathing Issues)	o	o	o	_____ _____

Medical Problem:	Past	Present	Never	Comments
Gastrointestinal: (stomach, Bowel, Intestinal, Celiac Disease, Food Allergies)	o	o	o	_____
Dermatologic: (Skin Rashes, Psoriasis, Other)	o	o	o	_____
Genitourinary: (Kidney Disease, Urinary Problems, Other)	o	o	o	_____
Ear, Nose and Throat: (Tonsils, Sinus, Swelling, Lumps)	o	o	o	_____
Hematological: (Anemia, Bleeding Disorders, Other)	o	o	o	_____
Immunological Disorder / Infectious Disease: (Tuberculosis, Hepatitis, HIV, Other)	o	o	o	_____
Endocrine / Metabolic: (Diabetes, Thyroid, Other)	o	o	o	_____
Musculoskeletal: (Bursitis, Osteoporosis, Osteopenia, Tendonitis, Arthritis, Scoliosis, Other)	o	o	o	_____
Neoplastic Condition: (Cancer, Tumors, Other)	o	o	o	_____
Neuropsychiatric: (Depression, Seizures, Anxiety, Other)	o	o	o	_____
Other: (Women's Health Issues, Fever, Chills, Night Sweats, Heat / Cold Intolerance)	o	o	o	_____

Please list any surgeries you have undergone and the dates:

Please list all medications you are taking at this time:

Please list any allergies you may have:

Immediate family members who have:

Diabetes: _____

High Blood Pressure: _____

Heart Attack/Stroke: _____

High Cholesterol: _____

Breast /Ovarian Cancer: _____

Dementia / Alzheimer: _____

Colon Cancer: _____

Prostate Cancer: _____

Thyroid Disorder: _____

Alcoholism: _____

Depression/Suicide: _____

Other: _____

Emergency Contact: _____

Phone #: _____