

PATIENT HEALTH QUESTIONNAIRE

Please provide the following information by answering the questions below. Confidentiality is maintained with all responses.

1) Please list the symptoms for which you are seeking physical therapy treatment.

2) Approximately when did your symptoms begin? _____

3) How did your symptoms start? _____ Unsure

4) Have you had this problem in the past? Yes No If so, when ? _____

5) On a scale from 0-10 (0 = "No pain" & 10 = "The worst pain imaginable"), what is your pain:

At best: _____ At worst: _____ On average: _____

6) Have you received treatment for this problem from any other healthcare provider? Yes No

7) What tests have you had for this problem? X-rays ___ CT Scan ___ MRI ___ Other: _____

9) What is your occupation? _____ Does your injury impact your work? If so, please describe. _____

10) What is your approximate weight? _____ Approximate height? _____

11) Please list all prescriptions, over the counter (OTC), herbals & supplements. Please include drug name & strength, frequency and how it is taken.

Drug / Vitamin / Supplement	Dose	Frequency
e.g. Atenolol (pill)	25 mg.	Once a day

12) Please list any allergies that you have: _____

13) Do you have any of the following?

- Heart Disease
- High Blood Pressure
- Arthritis
- Artificial Joints
- Pacemaker
- Respiratory Problems
- Neurological Disorders
- Sensation Problems
- Kidney Problems
- Open Wounds (that won't heal)
- Incontinence
- Urinary Tract Infections
- Radiation/Chemotherapy
- Other

14) Have you had any surgeries in the past year? If yes, please describe: _____

15) Have you experienced any of the following?

- Numbness in one or both hands or feet? Yes No
- Numbness in the saddle region (where you sit)? Yes No
- Loss of balance or taken a fall recently? Yes No
- Problems with coordination or weakness Yes No
- Unexplained weight loss/gain of 10 lbs in the past month? Yes No
- Changes in bladder or bowel habits? Yes No

Name (Signature) **Date**

Name (Printed)