

Patient Health Questionnaire

Patient Name

DOB

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assist your therapist in a more thorough understanding of your health.

PAST	PRESENT	
Y/N	Y/N	Blood Pressure
Y/N	Y/N	Angina
Y/N	Y/N	Heart Attack
Y/N	Y/N	Cancer – if yes, location: _____
Y/N	Y/N	Tumor
Y/N	Y/N	Lupus
Y/N	Y/N	Epilepsy
Y/N	Y/N	Diabetes
Y/N	Y/N	Rheumatoid Arthritis
Y/N	Y/N	Arthritis
Y/N	Y/N	Pacemaker
Y/N	Y/N	Stroke
Y/N	Y/N	Asthma
Y/N	Y/N	Pregnancy
Y/N	Y/N	Tobacco – if yes, packs/day: _____
Y/N	Y/N	Drug or Alcohol Dependence
Y/N	Y/N	Other: _____

Present: Weight _____ **Height** _____ **feet** _____ **in.**

ARE YOU ALLERGIC TO ANY MEDICATIONS _____

PLEASE LIST CURRENT MEDICATIONS, INCLUDING OVER-THE-COUNTER MEDICATION :

HOSPITALIZATIONS/SURGICAL PROCEDURES: _____

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In the space below, please describe your major complaint.
Please describe how your problem began or limitation:

Please tell us when your condition started:

_____ Specific Date if possible: _____

Did you have surgery? No Yes Date: _____

Indicate the intensity of your *pain at rest*: (1 = No Pain) ____ (10 = Unbearable Pain)

Indicate the intensity of your *pain with movement*: (1 = No Pain) ____ (10 = Unbearable Pain)

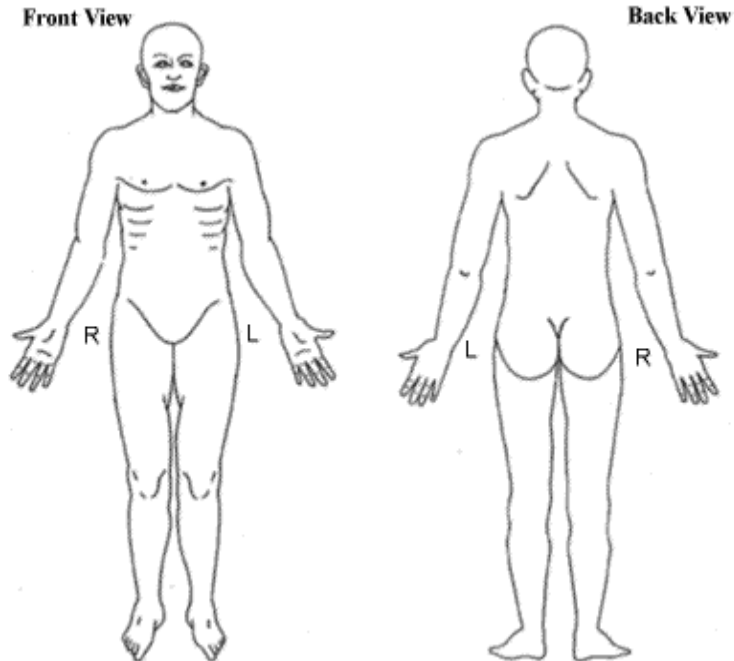
Since this condition began your symptoms have: decreased / not changed increased

Your Symptoms are worse in: morning /afternoon /night increased during the day/ same all day

In the past have you been treated for the same problem? Yes / No

If yes, who did you see for that condition? MD Physical /Therapist/ Occupational /Therapist
Chiropractor /Other _____

When and what treatment did you receive? _____



Patient Name: _____ Patient Signature: _____ Date _____

PHYSICAL THERAPIST SIGNATURE _____ Date _____