



PATIENT HEALTH QUESTIONNAIRE

Name _____

In the space below, please describe your major complaint.

Please describe how your problem began or limitation: _____

Please describe how your problem began: _____

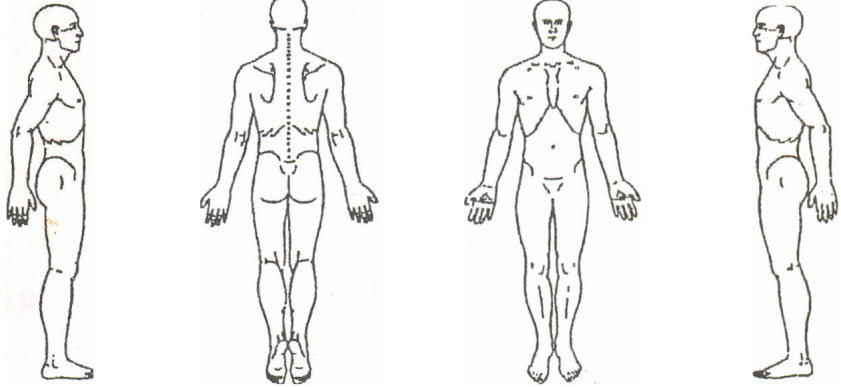
Please tell us when your condition started: _____ Specific Date if possible: _____

Did you have surgery? No Yes Date: _____

Please describe the nature of your pain:

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

MARK ON PICTURE WHERE →→→→→
YOU HAVE PAIN OR OTHER SYMPTOMS.



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? _____

Occupation. _____ Has your work status changed because of this condition YES NO

If you have ever had a listed condition in the past, please check if 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 assists your therapist in more thoroughly understanding your state of health.

PAST PRESENT

- High Blood Pressure (401.9)
- Angina (413.9)
- Heart Attack (410.9)
- Stroke (436)
- Asthma (493.9)
- Pacemaker
- Cancer (199.1) Location:
- Tumor (229.9)
- Lupus (710.0)
- Hepatitis (573.3)
- Epilepsy (349.5)
- Diabetes (250.0)
- Rheumatoid Arthritis (714.0)
- Arthritis (716.9)
- Pregnancy
- Other
- Tobacco (305.1) packs/day
- Drug or Alcohol Dependence (303.9)

Hospitalization/Surgical Procedures (list if not described elsewhere):

Date: _____

Medication:

Present: Weight _____ Height _____ feet _____ in.

Patient's Signature: _____ Date: _____