PATIENT HEALTH QUESTIONNAIRE

NAME _____ DATE ____/____/____

1. Please describe your Current Complaint/Limitation and how it began _____

_____

_____

2. When did your problem begin? _____ Specific Date if possible __/__/__

3. What causes the pain/symptom to **INCREASE**? _____

_____

_____

4. Your symptoms are worse: □ morning □ afternoon □ night □ during the day □ same all day

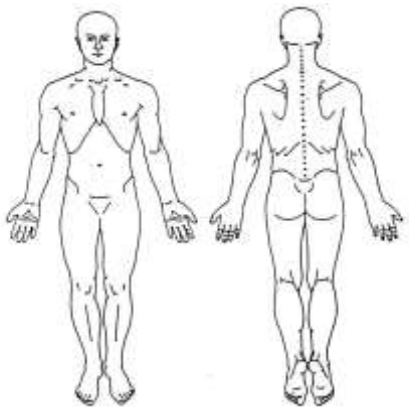
5. What causes the pain/symptom to **DECREASE**? _____

_____

6. Please describe the nature of your pain:

□ Sharp pain	□ Constant	(76-100% of the time)
□ Dull Ache	□ Frequent	(51-75% of the time)
□ Throbbing	□ Occasional	(25-50% of the time)
□ Numbness	□ Intermittent	(25% or less)
□ Shooting		
□ Burning		
□ Tingling		

Mark on the picture where you have pain or other symptoms →



7. Indicate the intensity of your pain

AT WORST: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

CURRENT: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

AT BEST: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

8. IN THE PAST, have you been treated for the same problem? □ Yes □ No

□ MD □ Physical Therapist □ Massage □ Chiropractor □ Other _____

CURRENTLY, are you receiving other services for this condition? □ Yes □ No

□ MD □ Physical Therapist □ Massage □ Chiropractor □ Other _____

9. What is your **GOAL** for physical therapy? _____

_____

_____

10. Occupation _____ Has your work status changed because of this condition? □ Yes □ No

11. What is your current work/school status? □ F/T, No restrictions □ P/T, No restrictions □ Retired □ Unemployed

□ F/T, with restrictions □ P/T, with restrictions □ F/T student □ F/T homemaker

12. Please list all **MEDICATIONS/PRESCRIPTIONS** you are currently taking _____

13. Please list all **ALLERGIES** _____

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14. Please describe your **GENERAL HEALTH** (please circle) Excellent Good Fair Poor

15. FAMILY HISTORY: Please check if any blood relative has had the following:

□ Obesity	relation _____	□ Arthritis	relation _____
□ Diabetes	relation _____	□ Heart Disease	relation _____
□ High Blood Pressure	relation _____	□ Stroke	relation _____
□ Cancer	relation _____	□ Tuberculosis	relation _____
□ Kidney Disease	relation _____	□ Other _____	relation _____

Injury as a result of a fall in the past year? Yes No Two or more falls in the last year? Yes No

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 assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
□	□	High Blood Pressure
□	□	Angina
□	□	Heart Attack
□	□	Stroke
□	□	Asthma
□	□	HIV/AIDS
□	□	Cancer Location: _____ Date _____
□	□	Tumor
□	□	Systemic Lupus
□	□	Hepatitis
□	□	Epilepsy
□	□	Diabetes
□	□	Rheumatoid Arthritis
□	□	Arthritis
□	□	Pregnancy
□	□	Other _____
□	□	Tobacco packs/day _____
□	□	Drug or Alcohol Dependence
□	□	Coffee/Tea/Caffeine drinks cups/cans per day ____

Do you have a permanent disability? YES NO
□ □
Location _____
Date rating received _____
Rating Percentage _____%

Present Weight _____
Height ____ feet ____ inches

16. **HOSPITALIZATIONS/SURGERIES**

Month/Year	Hospital	Reason for hospitalization and outcome

17. Have you been receiving **Home Health Care** ? □ Yes □ No

I certify that the above information is correct to the best of my knowledge. I will not hold *Thrive Physical Therapy, Inc.* responsible for any errors or omissions that I may have made in the completion of this form.

_____

Patient Signature and/or Patient Guardian Date

_____Reviewed By

Date

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