Trisha Becker Physical Therapy

PATIENT HEALTH QUESTIONNAIRE

The information you provide concerning present and past conditions and diseases assists your therapist in more thoroughly understanding your state of health. Please answer to the best of your ability.

NAME_____ DOB: _____

Who referred you to physical therapy: _____

In the section below, please describe your current complaint or limitation.

Describe your current complaint: _____

Describe how/when your problem began: _____

_____

Have you had surgery for this? □ No □ Yes Date_____/_____/_____

Check all the words that apply to your current complaint:

□ Sharp pain
□ Dull ache
□ Throbbing
□ Numbness
□ Shooting
□ Burning
□ Tingling
□ Weakness

□ Constant (76-100% of the time)
□ Frequent (51-75% of the time)
□ Occasional (26-50% of the time)
□ Intermittent (25% or less of the time)

□ Worse in the morning
□ Worse in the afternoon
□ Worse in the evening
□ Worse at night/sleep
□ Increased as day progresses
□ Same all day
□ Increase with activity

What activities or positions make your symptoms better? _____

What activities or positions make your symptoms worse? _____

Since this condition began, are your symptoms: □ Better □ Same □ Worse

Have you had any of the following tests because of your current symptoms?
□ X-ray □ CT/CAT Scan □ MRI □ Other

In the past, have you been treated for the same problem: □ Yes □ No
If yes, who did you see for that condition? _____
What treatment did you receive? _____
Was the treatment helpful? □ Yes, mostly improved □ Somewhat improved □ Not at all

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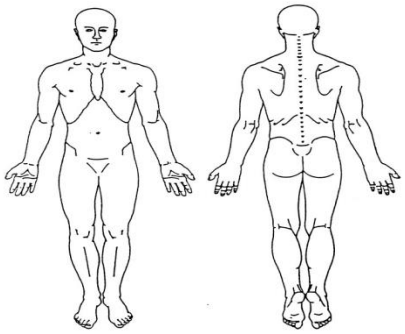
Occupation_____ Years in this position_____
Has your work status changed because of this condition? □ Yes □ No

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Rate your ***current level*** of pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Rate your level of pain ***at rest***: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Rate your level of pain ***with activity***: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

In the section below, please describe your past medical and family history.

Please indicate any of the following providers you are currently seeing:

□ Medical doctor (MD) □ Psychiatrist/psychologist □ Acupuncturist
□ Osteopathic doctor □ Chiropractor □ Other:
□ Natural medicine doctor □ Massage therapist _____

I would rate my health as (circle): EXCELLENT GOOD FAIR POOR
What was the date of your last physical? _____/_____/_____
For Women ONLY: Date of last Well Woman Exam_____/_____/_____ Mammogram___/___/___
For Men ONLY: Date of last prostate exam _____/_____/_____

Please describe any **INJURIES** for which you have been treated and approximate dates

List any **MEDICATIONS** that you are currently taking, **INCLUDING** over-the-counter medications:

List **ANY** hospitalizations and surgical procedures and approximate dates

Have **YOU** recently noticed any of the following symptoms in the **last 6 months**?

□ Fever	□ Unexplained sweating/Night sweats	□ Weight Loss/Gain
□ Nausea	□ Vomiting	□ Diarrhea
□ Paleness of skin	□ Dizziness/fainting	□ Fatigue/Tiredness

Have YOU or anyone in your family (parents, brothers, sisters) ever been diagnosed with the following? Please list anything additional not on list.

Angina/Chest pain	YOU	FAMILY	Anxiety/Panic attacks	YOU	FAMILY
Heart Attack	YOU	FAMILY	Eating Disorders	YOU	FAMILY
High blood pressure	YOU	FAMILY	Depression	YOU	FAMILY
High cholesterol	YOU	FAMILY	Drug/alcohol Abuse	YOU	FAMILY
Rheumatic fever	YOU	FAMILY	Polio/post-polio	YOU	FAMILY
Circulation problems	YOU	FAMILY	Fibromyalgia	YOU	FAMILY
Blood Disorders	YOU	FAMILY	Arthritis	YOU	FAMILY
Anemia	YOU	FAMILY	Gout	YOU	FAMILY
Asthma	YOU	FAMILY	Joint replacement	YOU	FAMILY
Allergies/Hay fever	YOU	FAMILY	Osteoporosis	YOU	FAMILY
Other Lung Disease	YOU	FAMILY	Skin Problems	YOU	FAMILY
Shortness of breath	YOU	FAMILY	Thyroid Problems	YOU	FAMILY
Diabetes	YOU	FAMILY	Liver Disease	YOU	FAMILY
Epilepsy/seizures	YOU	FAMILY	Food Poisoning	YOU	FAMILY
Cancer	YOU	FAMILY	Acid Reflux/GERD	YOU	FAMILY
Tumor	YOU	FAMILY	Kidney stones	YOU	FAMILY
Headache	YOU	FAMILY	Kidney Disease	YOU	FAMILY
Stroke	YOU	FAMILY	Urinary problems	YOU	FAMILY
Prostate problems	YOU	FAMILY	Endometriosis	YOU	FAMILY
Pregnancy	YOU	FAMILY	STDs	YOU	FAMILY
Tobacco Use	YOU	FAMILY	_____		
_____			_____		

FOR THERAPIST USE ONLY

_____ DATE_____

Patient Signature

_____ DATE_____

Therapist Signature