Trisha Becker Physical Therapy
Dr. Trisha Becker, PT, DPT, MHS, OCS
230 South Bemiston Avenue, Suite 1010
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PATIENT HEALTH QUESTIONNAIRE

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

NAME: DATE OF BIRTH:

REFERRED BY (if applicable):

CURRENT COMPLAINT

Describe your current complaint:

Describe how/when your problem began:

Have you had surgery for this? ☐ Yes ☐ No DATE:

Check ALL the words that apply to your current complaint:

FREQUENCY	INTENSITY	
☐ Constant (76-100% of the time)	☐ Sharp Pain	☐ Shooting
☐ Frequent (51-75% of the time)	☐ Dull Ache	☐ Throbbing
☐ Occasional (26-50% of the time)	☐ Burning Pain	☐ Weakness
☐ Intermittent (25% or less of the time)	☐ Tingling	☐ Numbness

TIME OF DAY

Morning	☐ Better	☐ Same	☐ Worse
Afternoon	☐ Better	☐ Same	☐ Worse
Evening	☐ Better	☐ Same	☐ Worse
Night/Sleeping	☐ Better	☐ Same	☐ Worse

☐ Symptoms the same all day

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

Activities or positions that improve symptoms?

Activities or positions that worsen symptoms?

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PATIENT HEALTH QUESTIONNAIRE P2

NAME: DATE OF BIRTH:

Have you had any of the following tests because of your current symptoms?

☐ X-rays ☐ CT/CAT Scan ☐ MRI ☐ Other

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

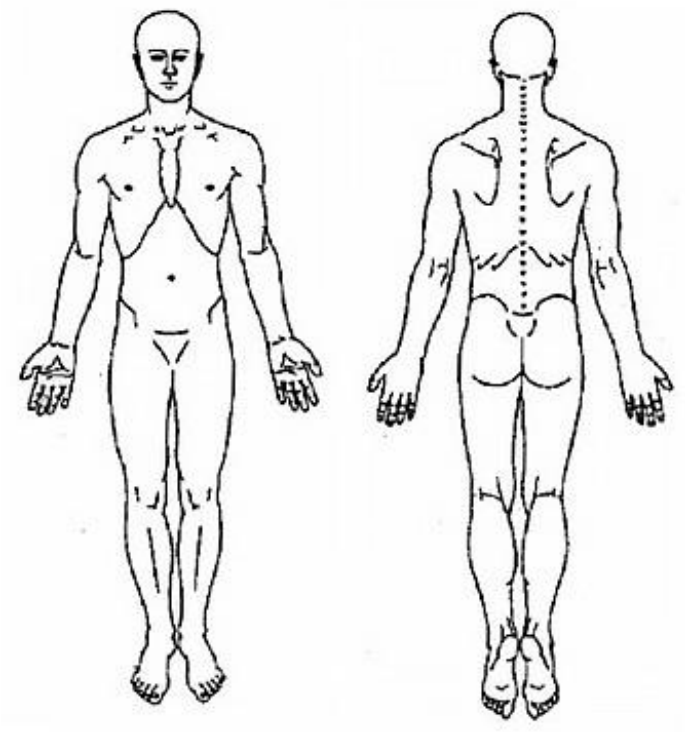
If yes, who did you see for that condition? _____

What treatment did you receive? _____

Was the treatment helpful? ☐ Yes ☐ No ☐ Somewhat

Occupation: Work Status Affected? ☐ Yes ☐ No

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Rate your current level of pain: (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Rate your level of pain at rest: (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Rate your level of pain with activity: (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

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PATIENT HEALTH QUESTIONNAIRE P3

NAME: DATE OF BIRTH:

PAST MEDICAL HISTORY

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

☐ Medical doctor (MD) ☐ Massage Therapist (LMT) ☐ Psychiatrist/psychologist
☐ Osteopathic doctor (DO) ☐ Acupuncturist (LAC) ☐ Other:
☐ Chiropractor (DC) ☐ Natural medicine doctor

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 / /

For Women ONLY: Date of last 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

List ANY hospitalizations and surgical procedures and approximate dates

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

☐ Fever ☐ Night Sweats ☐ Weight Loss/Gain ☐ Nausea
☐ Vomiting ☐ Diarrhea ☐ Dizziness/Fainting ☐ Fatigue/Tiredness

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PATIENT HEALTH QUESTIONNAIRE P4

NAME: DATE OF BIRTH:

Have YOU or anyone in your immediate family (parents, siblings) ever been diagnosed with the following? Please circle and 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	Polio/Post-polio	YOU	FAMILY
Rheumatic Fever	YOU	FAMILY	Fibromyalgia	YOU	FAMILY
Circulation Problems	YOU	FAMILY	Autoimmune Disease	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
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	Kidney Disease	YOU	FAMILY
Cancer	YOU	FAMILY	Kidney Stones	YOU	FAMILY
Tumor	YOU	FAMILY	Urinary Problems	YOU	FAMILY
Headache	YOU	FAMILY	Prostate Problems	YOU	FAMILY
Stroke	YOU	FAMILY	Food Poisoning	YOU	FAMILY
Acid Reflux/GERD	YOU	FAMILY	Tobacco Use	YOU	FAMILY
Endometriosis	YOU	FAMILY	Recreational Drug Use	YOU	FAMILY
Pregnancy	YOU	FAMILY	Drug/alcohol Abuse	YOU	FAMILY
STI/STD	YOU	FAMILY			

Patient Signature Date

Therapist Signature Date