

PATIENT HEALTH QUESTIONNAIRE

Name: _____

Date: ____/____/____

In the space below, please describe your major complaint.

Please describe your current complaint or limitation:

Please describe how your problem began:

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

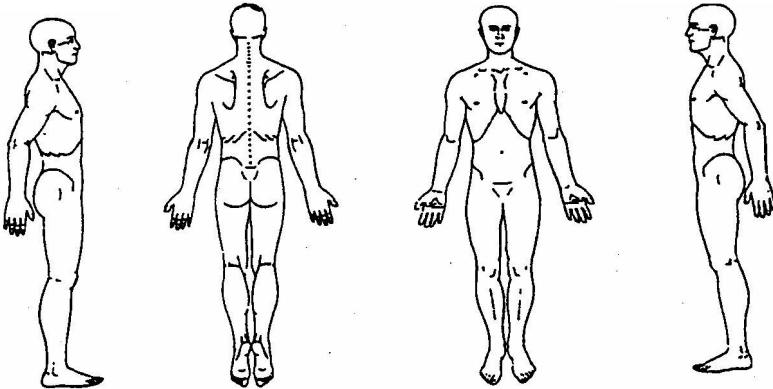
____/____/____

Did you have surgery? No Yes, Date: ____/____/____

Please describe the nature of you pain:

- | | |
|---|---|
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Constant (76-100%) |
| <input type="checkbox"/> Dull (Pain) Ache | <input type="checkbox"/> Frequent (51-75%) |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Occasional (26-50%) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Intermittent (25% or less) |
| <input type="checkbox"/> Shooting | |
| <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Tingling | |

**>>>>Mark on picture where you >>>>
have pain or other symptoms.**



Indicate the intensity of your pain at rest: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement: (No Pain) 0 1 2 3 4 5 6 7 8 9 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 ever had a condition in the past listed below, please check the PAST column. If you are presently troubled by a particular condition, check the present column. This information assists your Physical 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, if present: Due Date: ___/___/___
- Drug or Alcohol Dependence
- Allergy to Sulfur Drugs
- Allergy to Bromine
- Tobacco Use # of packs/day _____
- Other: _____

Hospitalization/Surgical Procedures:

Medications: _____

Present: Weight _____

Height _____ feet _____ inches

Patient's Signature

Date