Patient Health Questionnaire

Office Use Only

Name: _____ Date: _____

DOB / Age: _____ Next MD Appt: _____

Referring MD: _____ Primary Care Physician: _____

Primary Complaint: _____ Secondary Complaint: _____

Symptoms started / date? _____

How did symptoms begin? _____

How often do you feel symptoms? _____ Constantly _____ Frequently _____ Occasionally _____ Intermittently

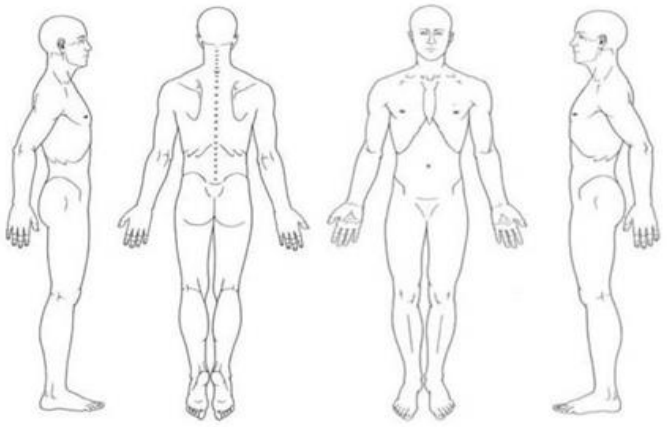
Since onset, are your symptoms? _____ Better _____ Worse _____ Same Other _____

Rate your pain (0-10 as below): _____ Today _____ Worst _____ Least _____ Average

0	1	2	3	4	5	6	7	8	9	10
No Pain	**Very Mild**	**Discomfort**	**Tolerable**	**Distressing**	**Very Distressing**	**Intense**	**Very Intense**	**Utterly Horrible**	**Excruciating**	**Unbearable**

Mark body with:

- **+ For pain**
- **− For numbness**
- **↓ For radiating pain**
- **◯ For tightness**



Description of your pain (check all that apply):

____ Dull Ache ____ Burning ____ Cramping
____ Deep Ache ____ Throbbing ____ Soreness
____ Sharp ____ Nagging ____ Numbness
____ Shooting ____ Squeezing ____ Tingling
____ Electrical ____ Zinging ____ Radiating
____ Stabbing ____ Twinge Other _____

Pain over course of day:
____ Increases ____ Decreases ____ Same

Pain at night:
____ No ____ Yes (if yes check below)
____ While lying still
____ When changing positions
____ Both

How do you sleep?
____ Stomach ____ Back
____ Right Side ____ All Positions
____ Left Side ____ Chair / Recliner

Other: _____

Additional Symptoms (if not described above): _____

_____

What makes it worse? _____

_____

What makes it better? _____

_____

Patient Health Questionnaire Continued

Since onset of symptoms have you experienced any of the following (check all that apply):

____ Difficulty with Bowel / Bladder Control ____ Fever or Chills _____ Numbness

____ Unexplained Weight Loss ____ Vision or Hearing Problems _____ Numbness in Genital /Anal Area

____ Dizziness or Fainting ____ Weakness Other_____

Have you been treated for this condition before? _____ No _____ Yes

(if yes) _____ MD _____ PT _____ Chiropractor Other: _____

Have you had diagnostics / tests for your current condition?

_____ None _____ X-Ray _____ MRI _____ CT Scam

_____ Bone Scan _____ EMG / NCV Other: _____

Where: _____ Results: _____

How would you rate your general health: _____ Excellent _____ Good _____ Fair _____ Poor

How often do you exercise: _____ Everyday _____ Frequently _____ Occasionally _____ Never

What type of exercise? _____

Dominant Hand: _____ Right _____ Left Do you use tobacco: _____ No _____ Yes _____ Former User

Are you currently pregnant? _____ No _____ Yes

Please indicate if you have had or currently have any of the following:

	Yes	Year		Yes	Year		Yes	Year
Stroke	___	____	Degenerative Joint Disease	___	____	Asthma	___	____
Heart Attack	___	____	Osteoporosis / Osteopenia	___	____	Headaches	___	____
High Blood Pressure	___	____	Multiple Sclerosis	___	____	COPD	___	____
Diabetes	___	____	Lupus / SLE	___	____	Hernia	___	____
Bowel / Bladder Issues	___	____	ALS / Lou Gehrig's	___	____	AIDS / HIV	___	____
Sensitivity to Heat / Cold	___	____	Tuberculosis	___	____	Skin Conditions	___	____
Peripheral Vascular Disease	___	____	Depression	___	____	Alzheimer's	___	____
Deep Vein Thrombosis / Clots	___	____	Parkinson's	___	____	Hepatitis	___	____
Arthritis	___	____	Polio	___	____	Alcoholism	___	____
Thyroid (Hyper / Hypo)	___	____	Epilepsy / Seizures	___	____	Drug Abuse	___	____
Cancer: _____		____	Other: _____		____	Other: _____		____

List any surgeries and dates: _____

_____

List any prescribed medications and what they are for: _____

_____

List any over the counter medication or vitamin supplements: _____

_____

List any allergies: _____

Patient Health Questionnaire Continued

Living Situation:
_____ Live Alone _____ Live with Spouse / Significant Other _____ Live with Family _____ Live with Caregiver
Other: _____

Functional Activity:
_____ Independent with Normal Daily Activities
_____ Require Assistance with Normal Daily Activities
_____ Minimal _____ Moderate _____ Maximal _____% of the Time

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Work History:
Occupation (Current or Former): _____

_____ Full Time _____ Part Time _____ Unemployed _____ Retired

_____ Self Employed _____ Student Other: _____

Job Requirements (check all that apply):

_____ Sitting _____ Standing _____ Phone Use _____ Computer Use

_____ Driving _____ Bending _____ Repetitive Lifting _____ Prolonged Position

_____ Heavy Lifting _____ Twisting Other: _____

Are you currently receiving or seeking disability benefits for this condition? _____ No _____ Yes

Do you have a previous disability from another condition? _____ No _____ Yes

Does your current condition limit normal work activities? _____ No _____ Yes

Do you plan to return to work? _____ No _____ Yes

Have you had physical therapy before? _____ No _____ Yes

What for? _____

Did you have a good prior physical therapy experience? _____ No _____ Yes

What would you like to achieve in physical therapy?

_____ Pain Relief _____ Increase Range of Motion ____ Increase Flexibility

_____ Return to Work _____ Improve Walking Tolerance / Ability ____ Improve Sleeping

_____ Return to Sport _____ Improve Activity Tolerance ____ Increase Strength

_____ Improve Posture _____ Improve Balance Other: _____

I understand by signing this medical intake form I have provided correct information to the best of my knowledge and give my written consent for physical therapy evaluation and treatment.

_____ _____

Patient Signature Date