

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: _____

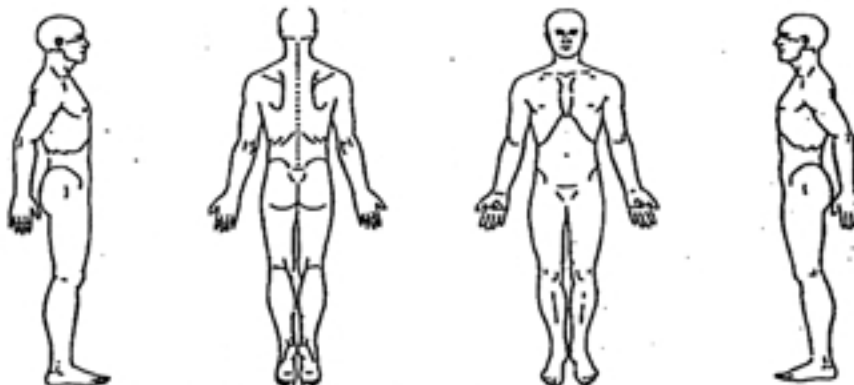
Please tell us when your condition started: _____ -- Specific Date if possible: ____/____/____

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

Please describe the nature of your 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 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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure (401.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina (413.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (410.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (436) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma (493.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS (042) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (199.1) Location: _____ Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor (229.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus (710.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (573.3) |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (349.5) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (250.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis (714.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (716.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco (305.1) packs/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence (303.9) |

Hospitalization/Surgical Procedures (list if not described elsewhere):

Medications: _____

Present: Weight _____ Height _____ feet _____ in.

Patient's Signature Date