Patient Health Questionnaire

Patient Name _____

Referring Physician _____ Date of first doctor visit for this injury _____

Primary Care Physician (if different than referring physician) _____

Have you had surgery for this injury? ☐ Yes ☐ No Number of surgeries _____

Type of surgery _____ Height: _____ft _____ in Weight: _____lbs

Occupation

Are you currently working? ☐ Light Duty ☐ Full Duty ☐ Not working If not working, date last worked): _____

Fall History

How many falls?_____ Injury? ☐ Yes ☐ No

If Yes, most recent occurrence: ☐ Last 6 weeks ☐ Last 6 months ☐ Last 12 months ☐ More than year

Symptoms

What problem(s) are you being treated for today? (Describe type and location of symptoms)

_____

What date (roughly) did your present symptoms start?_____

How did your problem(s) begin?_____

My symptoms are currently ☐ Getting better ☐ Getting worse ☐ Staying the same

My symptoms currently ☐ Come and go ☐ Are constant ☐ Constant, but change with activity

PAIN ASSESSMENT											
Please report a pain assessment on the scale below where 0 is no pain and 10 is the worst pain imaginable.											
	N/A	1	2	3	4	5	6	7	8	9	10
Pain at Rest	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pain with Activity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pain Range (best to worst)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

AGGRAVATING FACTORS		ALLEVIATING FACTORS	
Please list aggravating factors for pain (e.g. movement)		Please list alleviating factors for pain (e.g. laying down)	
1		1	
2		2	
3		3	

FUNCTIONAL PROBLEMS	
Please list any and all functional problems you currently have due to your diagnosis.	
1	
2	
3	

What is your goal for therapy? _____

Is there anything else we should know that is pertinent to your treatment?_____

_____

The above information is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

Patient Health Questionnaire (continued)

Have you had any of the following medical or rehabilitative services for this injury/episode?

Chiropractor	☐ Yes ☐ No	CT Scan	☐ Yes ☐ No
EMG/NCV	☐ Yes ☐ No	General Practitioner	☐ Yes ☐ No
Massage Therapy	☐ Yes ☐ No	MRI	☐ Yes ☐ No
Myelogram	☐ Yes ☐ No	Neurologist	☐ Yes ☐ No
Occupational Therapy	☐ Yes ☐ No	Orthopedist	☐ Yes ☐ No
Physical Therapy	☐ Yes ☐ No	Podiatrist	☐ Yes ☐ No
Emergency Room Care	☐ Yes ☐ No	X-Rays	☐ Yes ☐ No

Other: _____

Have you EVER HAD any of the following?

Asthma, Bronchitis, or Emphysema	☐ Yes ☐ No	Severe or Frequent Headaches	☐ Yes ☐ No
Shortness of Breath/Chest Pain	☐ Yes ☐ No	Vision or Hearing Difficulties	☐ Yes ☐ No
Coronary Heart Disease or Angina	☐ Yes ☐ No	Numbness or Tingling	☐ Yes ☐ No
Pacemaker or defibrillator	☐ Yes ☐ No	Dizziness or Fainting	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Heart Attack or Surgery	☐ Yes ☐ No	Weight Loss/Energy Loss	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Hernia	☐ Yes ☐ No
Blood Clot/Emboli	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Thyroid Trouble/Goiter	☐ Yes ☐ No	Any Pins or Metal Implants	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Infectious Disease	☐ Yes ☐ No	Neck Injury/Surgery	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Shoulder Injury/Surgery	☐ Yes ☐ No
Cancer or Chemotherapy/Radiation	☐ Yes ☐ No	Elbow/Hand Injury/Surgery	☐ Yes ☐ No
Arthritis/Swollen Joints	☐ Yes ☐ No	Back Injury/Surgery	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Knee Injury/Surgery	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Leg/Ankle/Foot Injury/Surgery	☐ Yes ☐ No
Sleeping Problems/Difficulties	☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No
Emotional/Psychological Problems	☐ Yes ☐ No	Are you pregnant? # weeks _____	☐ Yes ☐ No

Medications

Please list any allergies (i.e. latex, adhesives) _____

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No

☐ Anti-inflammatories

☐ Muscle Relaxers

☐ Pain Medication

List Medications _____

_____

_____

_____

_____

_____

The above information is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____