HAYES PHYSICAL THERAPY
PATIENT HEALTH QUESTIONAIRE

NAME:_____ DOB:_____ AGE:_____

Please indicate if you have any of the following:
(circle all that apply)

Allergies	Heart Disease	Neurological Disorder
Asthma	Hypertension	Osteoporosis
Cancer	Heart Surgery	Rheumatoid Disorder
Chemical Dependency	Hepatitis	Thyroid Dysfunction
Diabetes	Kidney Disease	Ulcers
Emphysema	Liver Disease	Other: _____
Epilepsy	Osteoarthritis	_____
Glaucoma		_____

Date of your last physical exam: _____

Recent Diagnostic Tests:_____

Please list any prior surgeries: _____

_____

Please your current medications (if you carry a list may we copy it?):_____

_____

_____

Briefly describe the reason for your visit today:_____

_____

When did this condition first occur:_____

Have you received PT or Chiropractor care for this condition in the past? When?_____

IN CASE OF EMERGENCY, CONTACT: _____

EMERGENCY CONTACT PHONE NUMBER:_____

RELATIONSHIP TO YOU:_____

_____ _____

Signature: Date: