PATIENT HEALTH QUESTIONNAIRE

SYMPTOMS

Please list the symptoms for which you are seeking physical therapy treatment:

When did your symptoms begin? / /	How did your symptoms start?

Have you had this problem in the past? ☐ Yes ☐ No	If "Yes", then when? / /	Have you received treatment for this problem from any other healthcare provider? ☐ Yes ☐ No

On a scale from 0-10 (0 = "No pain" & 10 = "The worst pain imaginable"), what is your pain:

At best: At worst: On average:

What tests have you had for this problem?

☐ X-rays? ☐ CT Scan ☐ MRI ☐ Other:

What is your occupation?	If your injury affects your work, please describe:
What is your approximate weight? (lbs)	What is your approximate height? (feet, inches)

Please list all prescriptions, over the counter, herbals & supplements. Please include drug name, dosage, and how frequently it is taken:

Drug / Vitamin / Supplement	Dose	Frequency

Please list any allergies that you have:

Do you have any of the following?

☐ Heart Disease	☐ Sensation Problems	☐ High Blood Pressure	☐ Kidney Problems
☐ Arthritis	☐ Open Wounds (that won't heal)	☐ Artificial Joints	☐ Incontinence
☐ Pacemaker	☐ Urinary Tract Infections	☐ Respiratory Problems	☐ Radiation/Chemotherapy
☐ Neurological Disorders	☐ Other:		

Have you had any surgeries in the past year? ☐ Yes ☐ No	If "Yes", please describe:

Have you experienced any of the following:

Numbness in one or both hands or feet?	☐ Yes	☐ No
Numbness in the saddle region (where you sit)?	☐ Yes	☐ No
Loss of balance or taken a fall recently?	☐ Yes	☐ No
Problems with coordination or weakness	☐ Yes	☐ No
Unexpected weight loss / gain of 10lbs in the past month?	☐ Yes	☐ No
Changes in bladder or bowel habits?	☐ Yes	☐ No

Name (Printed)	Name (Signature)	Date / /

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