

PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date: _____

In the spaces below, please describe your major complaint.

Please describe your current complaint or limitation _____

Please describe how your problem began: _____

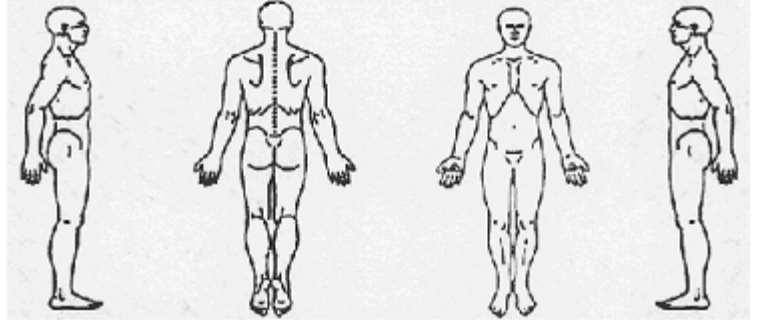
Please tell us when your condition started: _____ Specific Date if possible: ___/___/___

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

Please describe the nature of your pain:

- Sharp Pain Constant (76%-100%)
- Dull (Pain)Ache Frequent(51%-75%)
- Throbbing Occasional (26%-50%)
- Numbness Intermittent (25% or less)
- Shooting
- Burning
- Tingling

⇒ ⇒ ⇒ **MARK ON THE PICTURES 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

Have you been treated in the past 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 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: _____

		Allergies: _____

		Any other medical conditions we should be aware of: _____

		Patient's Signature _____