

# 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: \_\_\_\_\_

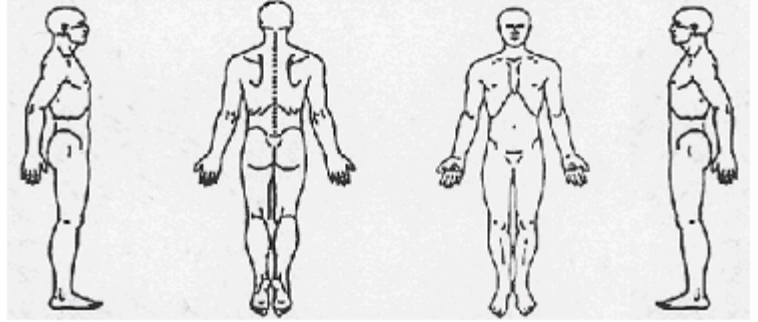
Please tell us when your condition started: \_\_\_\_\_ Specific Date if possible: \_\_\_/\_\_\_/\_\_\_

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, whom 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 assist 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: _____
		_____
		_____
		<b>Signature(Parent)</b> _____