Bon Secours Charity Health System - Patient Health Questionnaire

Name: ______________________________ Date of Birth: ______________________

Referring MD: __________________________ Next MD Appointment: ________________

Would you like a copy of your reports sent to your Primary MD? ☐ Yes ☐ No
If yes: Primary MD Name: ________________________ Fax: __________________

Current complaint or limitation: ____

Date of Injury/Onset: _____________________ ☐ Work Related ☐ Auto Accident ☐ School Injury

If your injury is the result of an accident, in what State did the accident occur? ____________________

If your injury is the result of an accident, is there currently any legal action being pursued? ☐ Yes ☐ No

Occupation: ____________________________ Present work status: ___________________

Please list any surgeries and dates below: ____

____

What is your goal for therapy? ____

Do you have any other aches and pains we should know about? ☐ Yes ☐ No

If Yes, please describe: ____

Past Medical History - Please check all that are applicable:

☐ High Blood Pressure	☐ Stroke	☐ Hepatitis	☐ Heart Attack
☐ HIV/AIDS	☐ Systemic Lupus	☐ Asthma	☐ Depression
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Pacemaker	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Tuberculosis	☐ Latex Allergy	☐ Currently Pregnant
☐ Osteoarthritis	☐ Angina	☐ Osteoporosis	Other: __________

☐ Cancer - Location(s) and Date(s): ____

Please list any current medications with dosages you are presently taking (including prescription, over-the-counter, herbals, vitamins/minerals/dietary or nutritional supplements).

Medication	Dosage	Medication	Dosage

☐ Please see attached copy of medication list provided by the patient. ☐ I am not taking any medication.

Please list any X-rays, CT scans, or MRI tests performed and the results: ______________________

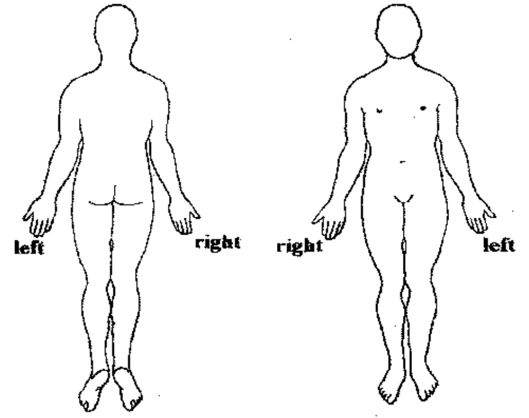
____

Have you had physical therapy in the past for this same problem? ☐ Yes ☐ No

Have you had any physical/occupational/speech therapy visits this year? ☐ Yes ☐ No
Number of therapy visits received this year: ____________

ACCESS PHYSICAL THERAPY & WELLNESS
Preferred by Patients, Trusted by Physicians

Name: ______________________________



Please indicate the intensity of your pain at its worst:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Please indicate the intensity of your pain at its best:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Please circle the description of your pain (any that apply):

Sharp Dull Throbbing Numbness
Shooting Burning Tingling
Constant (>76%) Frequent (51-75%)
Occasional (25-50%) Intermittent (<25%)

On the diagram to the right, mark the location(s) of your pain.

What increases the pain? ____________________________What decreases the pain? ____________________

Over the past 12 months, have you fallen 2 or more times? ☐ Yes ☐ No

Over the past 12 months, have you had 1 or more falls that resulted in injury? ☐ Yes ☐ No

Were you in a hospital or skilled nursing facility within the past 30 days? ☐ Yes ☐ No
If yes, reason for hospital stay _________________ Dates of stay: From: ______________To:______________

Have you recently received any type of home care services? ☐ Yes ☐ No
What was the last date anyone came into your house for services? __________________________

Do you smoke or use smokeless tobacco products? ☐ No ☐ Yes, I smoke _____ packs per day
☐ Yes, I use smokeless tobacco products _____ times per day

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many per day? ____ How many per week? _____

I would prefer to be treated by: ☐ Male Therapist ☐ Female Therapist ☐ It does not matter

If you require specialized services (like vestibular, concussion, or lymphedema/oncology, Occupational therapy or Speech Therapy) there may not be a choice available

I would prefer to be treated: ☐ Behind a privacy curtain ☐Where ever the therapist decides is most appropriate which may include shared gym spaces ***Certain equipment or certain activities can only be performed in the open gym area***

Do I feel safe at home? ☐Yes ☐No ☐Unable to say at this time.

Please let us know how you heard about our facility: ☐ Sign ☐ Insurance ☐ I was a previous patient ☐
☐ Dr. __________________________ ☐Other____

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Patient or Authorized Representative Signature: ________________________________ Date: ____________

Therapist Signature: ____ Date:___________________