FOR INTERNAL USE ONLY:

Height: _________ Weight: __________

BMI: ___________________________

Date: __________ Initials: _________

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 below any current medications, including dosage and route, you are presently taking (including prescription, over-the-counter, herbals, vitamins/minerals/dietary or nutritional supplements).

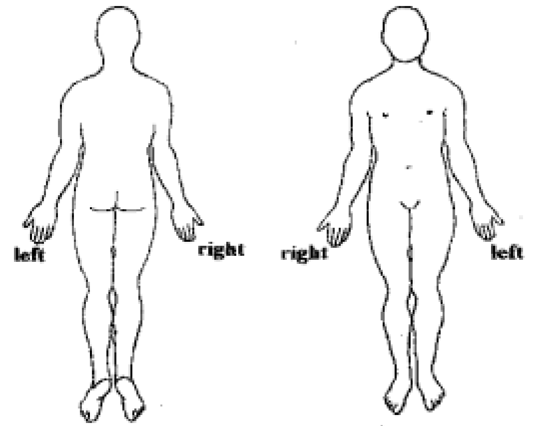
☐ Please see attached copy of medication list provided ☐ Not taking any medication.

Name of Medication	**Dosage**	**Route (by mouth, patch, injection, etc.)**

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

____

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? ____

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

Have you had any physical/occupational/speech therapy or chiropractic visits this year? ☐ YES ☐ NO
Number of therapy visits received this year for: PT ________ OT ________ Speech ________

Were you in a hospital or skilled nursing facility within the past 30 days? ☐ YES ☐ NO
If yes, reason for 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 home for services? ____________________

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

Do you smoke or use smokeless tobacco products?
☐ No, I do not use tobacco products ☐ Yes, I smoke _____ packs per day
☐ Yes, I use smokeless tobacco products _____ times per day

Do you drink alcoholic beverages? ☐ No ☐ Yes
How many alcoholic drinks per day? _____ How many alcoholic drinks per week? _____

Please let us know how you heard about our facility:
☐ Sign out front ☐ Mailing ☐ Insurance Directory ☐ I was a previous patient
☐ A previous patient (please specify) ________________ ☐ Newspaper ad
☐ Dr. ________________ ☐ Phone book (please specify) ____________________
☐ Friend/Family (please specify) ____________________ ☐ Other: ____________________________

Is there someone specific we may thank for referring you to us? ☐ Yes: ________________________ ☐ No

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: ____________________