



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:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Systemic Lupus | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Angina | <input type="checkbox"/> Osteoporosis | Other: _____ |
| <input type="checkbox"/> 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.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

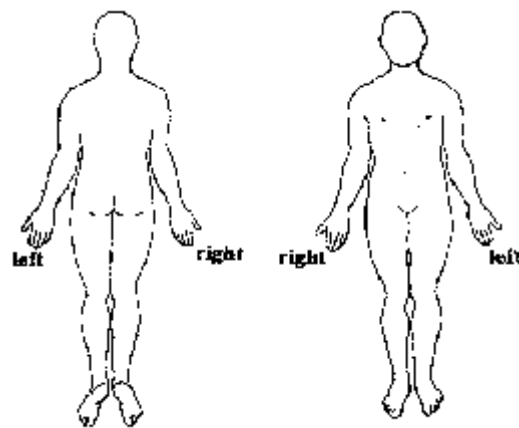
Please list any X-rays, CT scans, or MRI tests performed and the results: _____

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: _____