Physical Therapy &
Sports Medicine

Patient Health Questionnaire

Name_____ Age_____ Occupation_____
Diagnosis_____ Physician_____

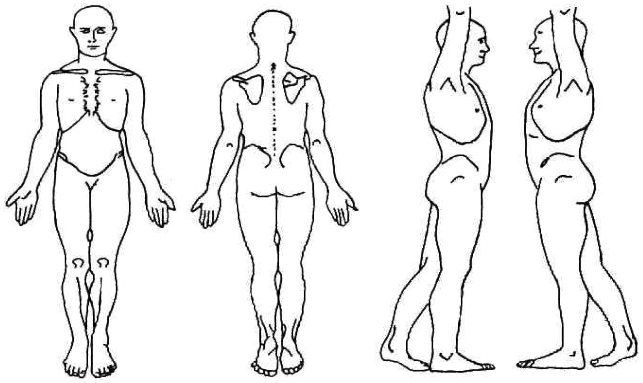
Date of Injury_____ Date of Surgery (if applicable)_____

Auto Accident? YES NO Date of Accident_____

Please describe how your injury/pain occurred:_____
_____
_____
_____

Regarding this injury, have you had an: ____X-Ray ____MRI ____CT Scan ____EMG ____Lab/Blood Work
If yes, do you have the results?_____

Please mark on the drawings the areas where you feel your symptoms and describe them:
___Constant
___Intermittent
___Burning
___Shooting
___Dull
___Achy
___Sharp
___Numb
___Tingling
___Throbbing
___Other _____



Please rate and/or describe your pain pattern throughout the day:
(you may use the 0-10 pain scale, where 0 is no pain and 10 is the worst imaginable pain)
Morning_____Afternoon_____Evening_____Night_____

Have your symptoms been:
Increasing_____ Decreasing_____ Plateaued_____
Do you have increased pain with coughing, sneezing, urination, or bowel movements?_____

What makes your pain/symptoms better? (ie.medications, ice, rest, etc.)_____
What makes your pain/symptoms worse? _____
Have you received treatment for this injury previously? If so, what and when? _____

_____ OVER →

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What activities at home, work, or school are you limited from performing because of this pain/injury?

_____Driving _____Stairs ____Laundry _____Standing for prolonged periods
_____Cooking _____Child Care ____Computer Work
_____Lifting _____Cleaning ____Sitting for prolonged periods
____Hobbies(please list)_____
____Sports (please list)_____
____Other (please list)_____

Do you currently have, or have had in the past any of the following conditions?

__yes __no Diabetes
__yes __no High Blood Pressure
__yes __no Hypoglycemia
__yes __no Heart Disease
__yes __no Heart Attack
__yes __no Angina/Chest Pains
__yes __no Shortness of Breath
__yes __no Allergies
__yes __no Asthma/Hay Fever
__yes __no Pneumonia
__yes __no Emphysema/COPD
__yes __no Anemia
__yes __no Osteoarthritis
__yes __no Rheumatoid Arthritis
__yes __no Hernia (ventral, inguinal, etc.)
__yes __no Headaches/Migraines
__yes __no Ulcers/Stomach Problems
__yes __no Kidney Diseases/Stones
__yes __no Liver Disease/Cirrhosis
__yes __no Stroke/CVA
__yes __no AIDS/HIV-positive
__yes __no Epilepsy/Seizures
__yes __no Thyroid Problems
__yes __no Fibromyalgia/Myofascial Pain Syndrome
__yes __no Multiple Sclerosis
__yes __no Nervous Disorders
__yes __no Currently Pregnant or Breast Feeding
__yes __no Osteoporosis/Osteopenia
__yes __no Cancer (if yes, please list)_____
__yes __no Previous Surgery _____
Other_____
Please give any additional details to the checked conditions:_____
_____

Do you have any allergies to medications, latex, heat/ice?_____
Do you have a pacemaker, transplanted organ, or metal implants?_____

Please list ALL medications you are currently taking and what they are for: (including over the counter medications)_____
_____
_____

Have you noticed any of the following changes in the past 6 months:

__yes __no Unintentional weight loss/gain >25 lbs
__yes __no Night Sweats
__yes __no Excessive Fatigue
__yes __no Unexplained Fever/Chills
__yes __no Unexplained Naseau/Vomiting
__yes __no Numbness/Tingling/Weakness

Do you smoke or chew tobacco? __Yes __No If yes, how many packs/day? _____ For how long?_____

How much caffeine do you consume daily?_____
Are you on any special diet prescribed by a physician? __Yes __No Describe:_____

_____ _____
Signature Date