



**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

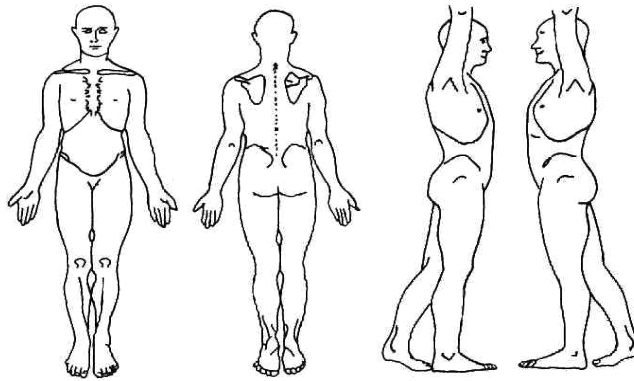
___ Sharp

___ 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 →

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 Hernia (ventral, inguinal, etc.)
- yes no High Blood Pressure yes no Headaches/Migraines
- yes no Hypoglycemia yes no Ulcers/Stomach Problems
- yes no Heart Disease yes no Kidney Diseases/Stones
- yes no Heart Attack yes no Liver Disease/Cirrhosis
- yes no Angina/Chest Pains yes no Stroke/CVA
- yes no Shortness of Breath yes no AIDS/HIV-positive
- yes no Allergies yes no Epilepsy/Seizures
- yes no Asthma/Hay Fever yes no Thyroid Problems
- yes no Pneumonia yes no Fibromyalgia/Myofascial Pain Syndrome
- yes no Emphysema/COPD yes no Multiple Sclerosis
- yes no Anemia yes no Nervous Disorders
- yes no Osteoarthritis yes no Currently Pregnant or Breast Feeding
- yes no Rheumatoid Arthritis 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 Unexplained Fever/Chills
- yes no Night Sweats yes no Unexplained Nausea/Vomiting
- yes no Excessive Fatigue 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