Physical Therapy & Wellness of Richmond

PATIENT HEALTH QUESTIONNAIRE

Patient Name: ______________________________________ Date: ______________________________

CURRENT CONDITION/LIMITATION

Describe: ____

Medical Diagnosis: ____

Onset Date: _______/_______/_______ Surgery Date (if applicable): _______/_______/_______

Are you taking any prescription or non-prescription medications for THIS problem: ______Y ______N

If yes, please list: ____

In the past, have you been treated for THIS condition? _____Y _____N

If yes, _____MD _____Physical Therapist _____Massage Therapist _____Chiropractor _____Other

Currently, are you being treated for THIS condition? _____Y _____N

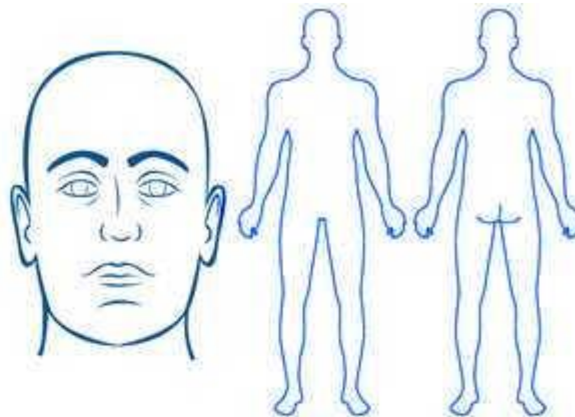
If yes, _____MD _____Physical Therapist _____Massage Therapist _____Chiropractor _____Other

Have you had diagnostic testing for THIS condition? _____Y _____N

If yes, _____ X-ray _____CT Scan/MRI _____EMG/NCV _____Myelogram _____Other

Results: ____

Mark on the picture your area of pain.



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PATIENT HEALTH QUESTIONNAIRE, CONTINUED

Intensity of your pain (0=No Pain; 10=Unbearable Pain):
AT REST: 0 1 2 3 4 5 6 7 8 9 10
WITH MOVEMENT: 0 1 2 3 4 5 6 7 8 9 10

Onset of your pain: ______Sudden ______Gradual

Frequency of your pain: ______Constant ______Frequent ______Occasional ______Rare

Description of your pain: ______Sharp ______Dull ______Throbbing ______Burning ______Shooting
______Numbness ______Tingling ______Localized ______Widespread

Behavior of your pain: Worse ______Morning ______Afternoon ______Evening ______Nighttime

Does your pain wake you at night? ______Y ______N If yes, ______x/week

What makes your pain/symptoms increase? ____
What makes your pain/symptoms decrease? ____

What is your general activity level? ______Inactive ______Moderately Active ______Very Active
What is your general stress level? ______Mild ______Moderate ______Severe

What are YOUR physical therapy goals?

1. ____
2. ____
3. ____

MEDICAL HISTORY

Please list ALL prescription and non-prescription medications currently taking.

____

____

Please list ALL allergies.

____

Please list ALL surgeries.

____

____

Have you had or do you currently have any of the following conditions:

Condition	Yes	No
Asthma	______YES	______NO
Bronchitis	______YES	______NO
Emphysema	______YES	______NO
High Blood Pressure	______YES	______NO
Chest Pain	______YES	______NO
Heart Attack	______YES	______NO
Stroke/TIA	______YES	______NO
Diabetes	______YES	______NO
Cancer	______YES	______NO
Thyroid Disease	______YES	______NO
Arthritis	______YES	______NO
Osteoporosis	______YES	______NO
Scoliosis	______YES	______NO
Bowel/Bladder Problems	______YES	______NO
Pregnancy	______YES	______NO
Depression	______YES	______NO
Dizziness/Fainting	______YES	______NO
Tinnitus (ringing in ears)	______YES	______NO
Tobacco Use	______YES	______NO