PATIENT HEALTH QUESTIONNAIRE

Name _____ ID # _____ Date ____/____/____

In the space below, please describe your major complaint.
Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us when your condition started: _____ Specific Date if possible: ___/___/___

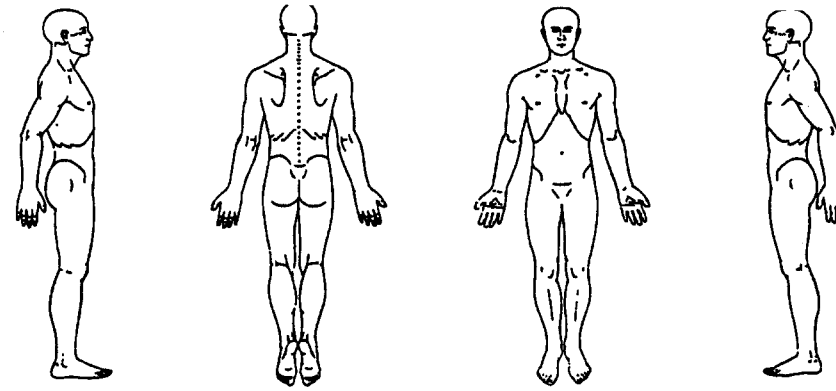
Did you have surgery? ☐ No ☐ Yes Date ____/____/____

Please describe the nature of your pain:

- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

- ☐ Constant (76 - 100%)
- ☐ Frequent (51 - 75%)
- ☐ Occasional (26 - 50%)
- ☐ Intermittent (25% or less)

→ → → → → **MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.**



Indicate the intensity of your ***pain at rest***: **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

Indicate the intensity of your ***pain with movement***: **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your Symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day.

In the past have you been treated for the same problem? ☐ Yes ☐ No

If yes, who did you see for that condition? ☐ MD ☐ Physical Therapist ☐ Occupational Therapist ☐ Chiropractor ☐ Other

When and what treatment did you receive? _____

Occupation _____ Has your work status changed because of this condition ☐ YES ☐ NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	HIV /AIDS (042)
☐	☐	Cancer (199.1) Location:_____ Date:_____
☐	☐	Tumor (229.9)
☐	☐	Systemic Lupus (710.0)
☐	☐	Hepatitis (573.3)
☐	☐	Epilepsy (349.5
☐	☐	Diabetes (250.0
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Arthritis (716.9)
☐	☐	Pregnancy
☐	☐	Other_____
☐	☐	Tobacco (305.1) packs/day_____
☐	☐	Drug or Alcohol Dependence (303.9)

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____
_____
_____
_____

Medications: _____
_____
_____
_____

Present: Weight_____ Height_____feet_____in.

_____
Patient's Signature Date