PATIENT HEALTH QUESTIONNAIRE

Name: _____ Height:_____ Weight:_____

In the space below, please describe your major complaint:

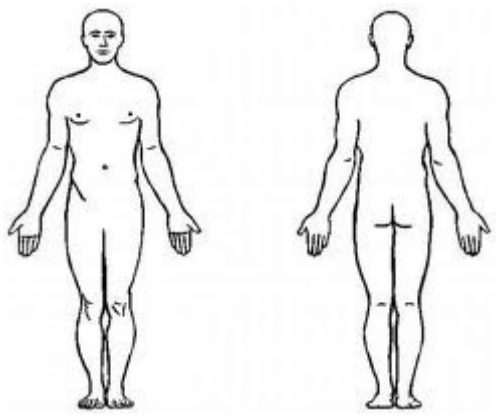
Please describe your current complaint or limitation:_____
Please describe how your problem began:_____
Please tell us when your condition started:_____Specific date if possible: __/__/____
Did you have surgery? □ No □ Yes Date: __/__/____

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)

Please mark on the picture where you have pain or other symptoms. →



Indicate the intensity of your pain *at rest*: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Indicate the intensity of your pain *with movement*: (No Pain) 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 never had a listed condition in the NO column, please check in the NO column. If you are presently troubled by a particular condition, check it in the YES column. The information you provide concerning yes and no conditions and diseases assists your therapist to better understand your state of health.

Yes	No		
□	□	High Blood Pressure (401.9)	X-rays/MRIs:_____
□	□	Angina (413.9)	Hospitalization/Surgical Procedures
□	□	Heart Attack (410.9)	_____
□	□	Stroke (436)	_____
□	□	Asthma (493.9)	_____
□	□	HIV/AIDS (042)	_____
□	□	Cancer (199.1) Location: _____ Date ____	Medications:_____
□	□	Tumor (229.9)	_____
□	□	Systemic Lupus (710.0)	_____
□	□	Hepatitis (573.3)	_____
□	□	Epilepsy (349.5)	Do you have any allergies? Yes □ No □
□	□	Diabetes (250.0)	If so, please list _____
□	□	Rheumatoid Arthritis (714.0)	_____
□	□	Arthritis (716.9)	
□	□	Latex Allergy	
□	□	Pregnancy	
□	□	Other _____	_____
□	□	Pacemaker	Patient's Signature Date