# Patient Health Questionnaire

*Please answer all questions as honestly and thoroughly as possible.*

Name _____ Date _____

1. Please describe your current major complaint or limitation.

_____

2. Please describe how your problem began. _____

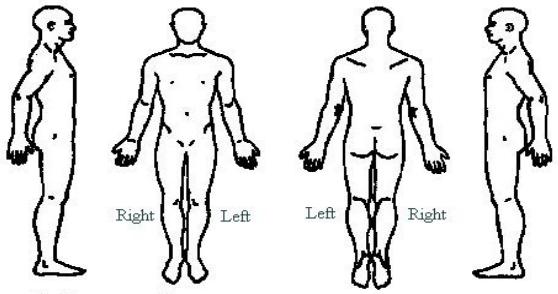
3. Please tell us when your condition started. _____ Specific date, if possible. ___/___/___

4. Did you have surgery? Yes / No If yes, date: ___/___/___

5. Please describe the nature of your pain and its consistency. (Check all that apply.)

□ Sharp pain
□ Dull pain/ache
□ Throbbing
□ Numbness
□ Shooting
□ Burning
□ Tingling

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




6. Please mark on the pictures to the right where your pain or other symptoms occur.

7. 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)

8. Since this condition began, your symptoms have: □ increased □ decreased □ not changed

9. Your symptoms are worse in the: □ morning □ afternoon □ evening □ increase during the day □ stay the same all day

10. In the past, have you been treated for this problem? Yes / No If yes, whom did you see for that condition?

□ MD □ Physical therapist □ Occupational therapist □ Chiropractor □ Other

When, and what treatment did you receive? _____

11. What is your occupation? _____ Has your working status changed as a result of this condition? Yes / No

12. *If you have ever had a condition listed below, please check it in the past column. If you presently have a condition below, please check it in the present column. This information assists the therapist in more thoroughly understanding your state of heath.*

| PAST | PRESENT | |
|---|---|---|
| □ | □ | High Blood Pressure |
| □ | □ | Angina |
| □ | □ | Heart Attack |
| □ | □ | Stroke |
| □ | □ | Asthma |
| □ | □ | HIV/AIDS |
| □ | □ | Cancer: Location: _____ Date: ___/___/___ |
| □ | □ | Tumor |
| □ | □ | Systemic Lupus |
| □ | □ | Hepatitis |
| □ | □ | Epilepsy |
| □ | □ | Diabetes |
| □ | □ | Rheumatoid Arthritis |
| □ | □ | Arthritis |
| □ | □ | Pregnancy |
| □ | □ | Other: _____ |
| □ | □ | Tobacco: Packs/day _____ |
| □ | □ | Drug or alcohol dependency |

Hospitalization/Surgical procedures (list if not described elsewhere:

_____
_____
_____

Medications:

_____
_____

Present Weight _____ Height _____

Patient Signature:

_____

Date: ____/_____/_____