Patient Health Questionnaire

Name____Age______Occupation ___________________________

If you are a student are you employed: ( ) full time ( ) Part-time Job ( ) Not employed

Job Duties____

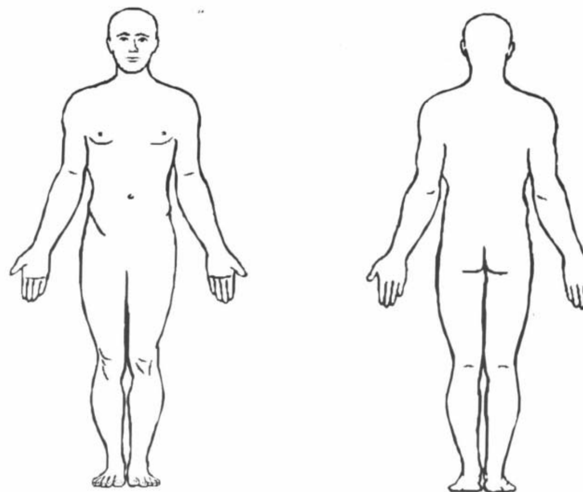
Describe the problem(s) for which you seek treatment____

____

How did your symptoms begin____

When did your symptoms start?______________________

Indicate where you have pain or other symptoms



What describes the nature of your symptoms?

( ) Sharp ( ) Shooting
( ) Dull ache ( ) Burning
( ) Numb ( ) Tingling

How often do you experience your symptoms?

( ) Constantly (76-100% of the day)
( ) Frequently (51-75% of the day)
( ) Occasionally (26-50% of the day)
( ) Intermittently (0-25% of the day)

Indicate the average intensity of your symptoms:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
0 1 2 3 4 5 6 7 8 9 0

Have you ever had this problem before? ________

Briefly state previous treatment, if any:____

____

Have you had any X-rays, CAT scans, MRIs, or other diagnostic tests for your recent injury? Yes___No___. If yes, please explain the findings, as you understand them:____

____

Please give us a complete list all the medicines that you currently or regularly take:___________________________

____

____

____

Current activity level (hobbies, sports, recreation, etc):____

____

Activities wishing to return to:____

____

Is there anything else you think I should know about your general health? Please explain and, if necessary, we can talk about it.____

____

Past Medical History

Have you experienced any of the following?

Yes **No**

[ ] [ ] **Orthopedic Surgery** ____

Yes	No		Yes	No	
Heart Disease:					
		Congestive Heart Failure (CHF)			Valvular Disease
		High Blood Pressure			Stents
		Heart Attack			Arrhythmia
		Atherosclerotic Disease			Coronary Artery Bypass
		Angioplasty			Angina
		Do you have a Pacemaker?			
Vascular Disease:					
		Chronic Obstructive Pulmonary Disease (COPD)			Respiratory Distress Syndrome
		Emphysema			Recent Pneumonia
		Peripheral Artery Disease			Stroke/TIA
		Blood Pressure Meds			Chronic Bronchitis
		Diabetes			Hypertension
		Asthma			
General Medical Conditions:					
		Arthritis (rheumatoid/osteoarthritis)			Osteoporosis
		Allergies			Anxiety or Panic Disorders
		Neurological Disease (such as MS or Parkinson’s)			Kidney, Bladder, Prostate or Urination Problems
		Headaches			Previous Accidents
		GI Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)			Visual Impairment (cataracts, glaucoma, macular degeneration)
		Depression			Incontinence
		Back Pain (neck pain, low back pain, degenerative disc disease			Hearing Impairment
		Hepatitis/AIDS			Sleep Dysfunction
		Prior Surgery			Prosthesis/Implants
		Cancer			

Explain____

____

Other Disorders____

In Case of Emergency Contact:
____Relationship:___________________

Home Phone:________________________ Work Phone ____________________________Cell:_________________________

Signed____ Date__________________