PATIENT HEALTH QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

PLEASE DESCRIBE YOUR SYMPTOMS: ______________________________

HOW DID YOUR SYMPTOMS START? ______________________________

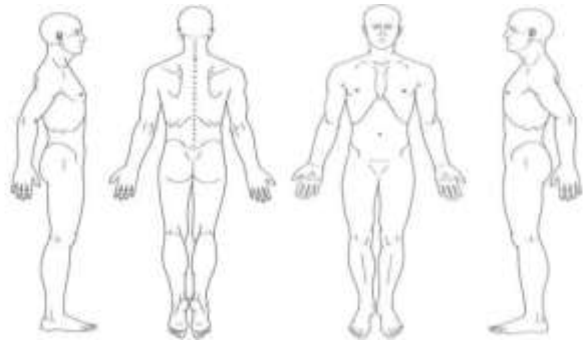
WHEN DID YOUR SYMPTOMS START? (SPECIFIC DATE IF POSSIBLE) ____/____/____

HAVE YOU HAD ANY X-RAYS OR MRI PERFORMED ON THIS BODY PART? ① YES ② NO DATE: ____/____/____

WHAT IS THE NAME OF THE FACILITY WHERE YOU HAD YOUR X-RAY OR MRI? ______________________________

DID YOU HAVE SURGERY? ① YES ② NO DATE: ____/____/____

INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS BELOW:



HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

① CONSTANTLY (76—100% OF THE DAY)
② FREQUENTLY (51—75% OF THE DAY)
③ OCCASIONALLY (26—50% OF THE DAY)
④ INTERMITTENTLY (0—25% OF THE DAY)

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

① SHARP ② SHOOTING
③ DULL ACHE ④ BURNING
⑤ NUMB ⑥ TINGLING

AVERAGE PAIN INTENSITY <u>AT REST</u>: (NONE) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (WORST PAIN)

AVERAGE PAIN INTENSITY <u>WITH MOVEMENT</u>: (NONE) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (WORST PAIN)

HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR USUAL DAILY ACTIVITIES?

① NOT AT ALL ② A LITTLE BIT ③ MODERATELY ④ QUITE A BIT ⑤ EXTREMELY

HOW IS YOUR CONDITION CHANGING, SINCE CARE BEGAN AT *<u>THIS</u>* FACILITY?

⓪ N/A (TODAY IS INITIAL VISIT) ① MUCH WORSE ② WORSE ③ A LITTLE WORSE ④ NO CHANGE ⑤ A LITTLE BETTER ⑥ BETTER ⑦ MUCH BETTER

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS…

① EXCELLENT ② VERY GOOD ③ GOOD ④ FAIR ⑤ POOR

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		PAST	PRESENT	
☐	☐	ANGINA	☐	☐	METAL IMPLANTS (PINS / PLATES / SCREWS)
☐	☐	ARTHRITIS	☐	☐	PACEMAKER
☐	☐	ASTHMA	☐	☐	PREGNANCY
☐	☐	CANCER	☐	☐	RHEUMATOID ARTHRITIS
☐	☐	DIABETES	☐	☐	STROKE
☐	☐	DRUG OR ALCOHOL DEPENDENCE	☐	☐	SYSTEMIC LUPUS
☐	☐	EPILEPSY	☐	☐	THYROID PROBLEMS
☐	☐	HEART ATTACK	☐	☐	TOBACCO USE
☐	☐	HEPATITIS	☐	☐	TUMOR
☐	☐	HIGH BLOOD PRESSURE	☐	☐	URINARY: RETENTION/INCONTINENCE
☐	☐	HIV / AIDS	☐	☐	OTHER ______________
☐	☐	LATEX ALLERGY			

IN THE PAST HAVE YOU BEEN TREATED FOR THE SAME PROBLEM? ① YES ② NO

HAS YOUR WORK STATUS CHANGED BECAUSE OF THIS CONDITION? ① YES ② NO

DO YOU HAVE A PERMANENT DISABILITY RATING? ① YES ② NO **LOCATION:** __________ **PERCENTAGE:** ____% **DATE:** ________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF YES, WHICH ONES? ______________________________

BY SIGNING BELOW YOU GIVE PERMISSION FOR LIFESPAN, PLLC TO OBTAIN INFORMATION FROM YOUR PHYSICIAN REGARDING YOUR CARE.

______________________________ ______________

PATIENT'S SIGNATURE **DATE**