PHYSICAL THERAPY – Patient Health Questionnaire PHQ

Patient Name: _____ Date: _____

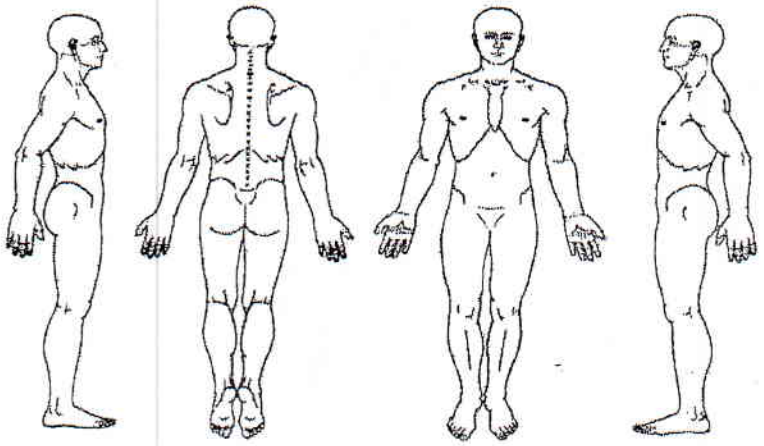
1. Describe your symptoms _____

   When did your symptoms start? _____

   How did your symptoms begin? _____

2. 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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptom
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

4. How are your symptoms changing?
   ① Getting better
   ② Not changing
   ③ Getting worse

5. During the past four weeks:
   Indicate the average intensity of your symptoms

   None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

   How much has pain interfered with your normal work (including both work outside the home and housework)?
   ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past four weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)
   ① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health now is. . .
   ① Excellent ② Very good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms: ① No one ② Chiropractor ③ Medical doctor ④ Physical therapist ⑤ Other

   What treatment did you receive and when? _____

   What tests have you had for your symptoms ① X-rays date: _____ ② MRI date: _____ ③ CT Scan date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past? ① Yes ② No

   If you have received treatment in the past for the same or similar symptoms , who did you see? ① This office ② Chiropractor ③ Medical doctor ④ Physical therapist ⑤ Other

10. What is your occupation? _____
    ① Professional/executive ② White collar/secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ Full-time student ⑦ Retired ⑧ Other

    If you are not retired, a homemaker, or a student, what is your current work status? ① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature _____ Date: _____

Family doctor: _____ **Referring doctor:** _____

Have you ever been diagnosed as having any of the following conditions?

YES NO Cancer. If yes, describe what kind:_____
YES NO Heart problems. Do you have a pacemaker?__
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependence (i.e. alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritis conditions_____
YES NO Gout
YES NO Depression

YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke/TIA
YES NO Kidney disease/chronic bladder infection
YES NO Anemia
YES NO Epilepsy
YES NO Pneumonia
YES NO Blood clots
YES NO Fibromyalgia
YES NO Ulcers
YES NO Headaches
YES NO Urinary incontinence
YES NO Osteoporosis
YES NO Other _____

Do you use an assistive device in order to walk? YES NO
During the past month, have you been feeling down, depressed or hopeless? YES NO
During the past month, have you been bothered by having little interest/pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries for which you have been hospitalized including the approximate date and reason:

Date	Reason for surgery	Date	Reason for surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury.

Date	Injury	Date	Injury
_____	_____	_____	_____
_____	_____	_____	_____

List any allergies: _____ **Are you allergic to Latex?** YES NO

Which of the following over-the-counter medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Tagamet/Zantac/Pepsid

YES NO Decongestants
YES NO Antihistamines
YES NO Antacids
YES NO Vitamins/mineral supplements
YES NO Other _____

Please list any prescription medications you are taking (including pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

What are your goals in coming for treatment? _____
_____

Have you recently noted:

YES NO Weight loss/gain
YES NO Dizziness/lightheadedness
YES NO Weakness
YES NO Numbness/tingling

YES NO Nausea/vomiting
YES NO Fatigue
YES NO Fever/chills/sweats

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