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Physical Therapy & Wellness of Richmond

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

CURRENT CONDITION/LIMITATION

Describe: _____

Medical Diagnosis: _____

Onset Date: _____/_____/_____ Surgery Date (if applicable): _____/_____/_____

Are you taking any prescription or non-prescription medications for THIS problem: _____Y _____N

If yes, please list: _____

In the past, have you been treated for THIS condition? _____Y _____N

If yes, _____MD _____Physical Therapist _____Massage Therapist _____Chiropractor _____Other

Currently, are you being treated for THIS condition? _____Y _____N

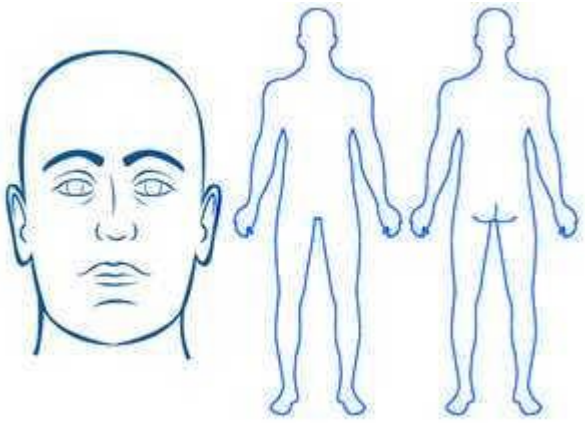
If yes, _____MD _____Physical Therapist _____Massage Therapist _____Chiropractor _____Other

Have you had diagnostic testing for THIS condition? _____Y _____N

If yes, _____ X-ray _____CT Scan/MRI _____EMG/NCV _____Myelogram _____Other

Results: _____

Mark on the picture your area of pain.



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PATIENT HEALTH QUESTIONNAIRE, CONTINUED

Patient Name: _____ Date: _____

Intensity of your pain (0=No Pain; 10=Unbearable Pain):
AT REST: 0 1 2 3 4 5 6 7 8 9 10
WITH MOVEMENT: 0 1 2 3 4 5 6 7 8 9 10

Onset of your pain: _____Sudden _____Gradual

Frequency of your pain: _____Constant _____Frequent _____Occasional _____Rare

Description of your pain: _____Sharp _____Dull _____Throbbing _____Burning _____Shooting
_____Numbness _____Tingling _____Localized _____Widespread

Behavior of your pain: Worse _____Morning _____Afternoon _____Evening _____Nighttime

Does your pain wake you at night? _____Y _____N If yes, _____x/week

What makes your pain/symptoms increase? _____
What makes your pain/symptoms decrease? _____

What is your general activity level? _____Inactive _____Moderately Active _____Very Active
What is your general stress level? _____Mild _____Moderate _____Severe

What are YOUR physical therapy goals?

1. _____
2. _____
3. _____

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PATIENT HEALTH QUESTIONNAIRE, CONTINUED

Patient Name: _____ Date: _____

MEDICAL HISTORY

Please list ALL prescription and non-prescription medications currently taking.

_____

_____

Please list ALL allergies.

_____

Please list ALL surgeries.

_____

_____

Have you had or do you currently have any of the following conditions:

Asthma	_____YES	_____NO
Bronchitis	_____YES	_____NO
Emphysema	_____YES	_____NO
High Blood Pressure	_____YES	_____NO
Chest Pain	_____YES	_____NO
Heart Attack	_____YES	_____NO
Stroke/TIA	_____YES	_____NO
Diabetes	_____YES	_____NO
Cancer	_____YES	_____NO
Thyroid Disease	_____YES	_____NO
Arthritis	_____YES	_____NO
Osteoporosis	_____YES	_____NO
Scoliosis	_____YES	_____NO
Bowel/Bladder Problems	_____YES	_____NO
Pregnancy	_____YES	_____NO
Depression	_____YES	_____NO
Dizziness/Fainting	_____YES	_____NO
Tinnitus (ringing in ears)	_____YES	_____NO
Tobacco Use	_____YES	_____NO