Patient Health Questionnaire

Name: _____ Date: _____

Please describe your current complaint or limitation: _____

Please describe how your problem began and when it started with specific date if possible: _____

_____

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)

Have you ever had surgery including this current condition? ○ Yes ○ No If yes, please list the type of surgery and date

Type:_____ Date_____ Type:_____ Date _____

Type:_____ Date_____ Type:_____ Date _____

Have you ever had therapy for your current condition? ○ Yes ○ No If yes, please list:

Location: _____ Dates:_____ # of visits: _____

Are we treating you as a result of an accident? ○ Yes ○ No If yes, please explain:_____

_____

Have you ever suffered from any of the following :

Past	Present		Past	Present	
○	○	High Blood Pressure	○	○	Seizures
○	○	Cardiac condition	○	○	Dizzy Spells
○	○	Heart Attack	○	○	Diabetes
○	○	Pacemaker	○	○	Allergies
○	○	Arthritis	○	○	Fractures
○	○	Rheumatoid Arthritis	○	○	Stroke
○	○	Osteoporosis	○	○	Pregnancy
○	○	Cancer _____	○	○	Tobacco
○	○	Vision Problems	○	○	Drug or Alcohol Dependence
○	○	Speech Problems	○	○	Other _____

Current Height:_____

Current Weight: _____

Medications List

Name	Prescribed by	Dosage mg/units/drops	How many times per day?	Purpose	Notes

Patient Signature: _____ Date: _____