FYZICAL Therapy & Balance Centers

Patient Health Questionnaire

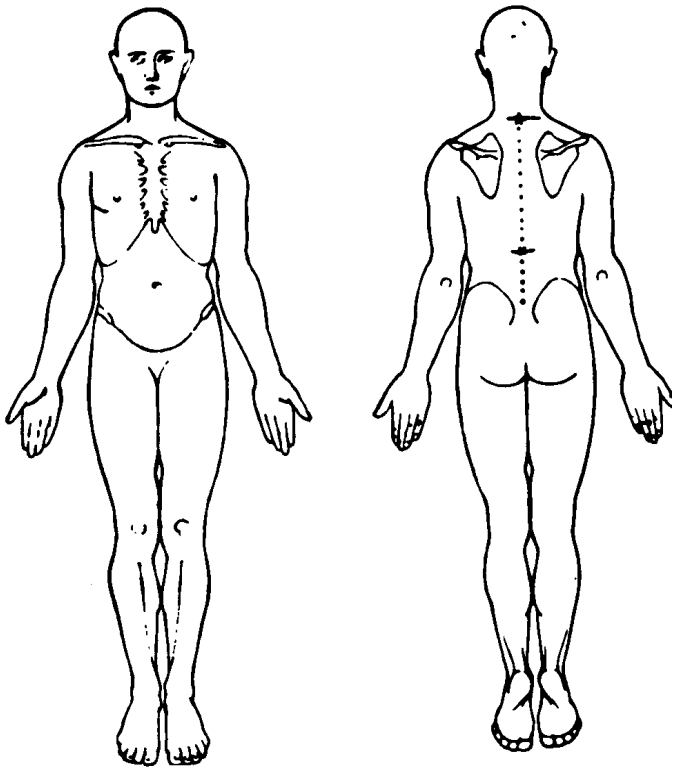
Patient Name_____ **Today's Date**_____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

Age_____ **Height**_____ **Weight**_____ **Occupation**_____

What is your chief complaint? (Diagnosis, symptoms or condition) _____

Draw your area of symptoms



Do you now have:

___ dizziness / fainting / seizures
___ night pain
___ numbness / weakness
___ shortness of breath
___ fever / chills
___ bowel/bladder control problems
___ numbness in the genital area
___ are you pregnant
___ poor circulation / bruising
___ artificial joints
___unexplained muscle weakness

Have you ever had:

___ cancer (type: _____)
___ heart problems / pacemaker
___ high blood pressure
___ diabetes
___ rheumatoid arthritis
___ tuberculosis / hepatitis / HIV
___ osteoporosis
___ asthma
___ stroke
___chest pain
___fainting or dizziness

Does pain awaken you at night? ☐No ☐Yes

Do you smoke? ☐No ☐Yes

Unexplained weight loss? ☐No ☐Yes

What test have you had for this problems? ☐x-ray ☐MRI ☐CT scan ☐other_____

Have you ever had surgery for this problem? ☐No ☐Yes List other surgeries _____

Are you feeling a high level of stress or anxiety? ☐No ☐Yes

Have you had difficulty with depression? ☐No ☐Yes

How would you rate your PAIN? (0 to 10: 0 = no pain, 10 = unbearable pain)

Right now _____ At Best _____ At Worst _____

What activities are the most troublesome for you? (circle any that apply)

Sleeping, bed mobility, dressing, bathing, other _____

Sitting, standing, walking, bending/lifting, housework, computer, reaching, other work_____

Sports – running, jumping, change of direction, other _____

Is there a physical reason not mentioned here why you should not follow an activity/exercise program? _____

If yes, please explain:_____

Please list any surgeries you have had: _____

_____

_____

What are your goals for physical therapy? _____

_____

_____

Have you fallen in the last year? ___YES ___ NO

Have you had more than one fall in the last year? (even a minor one) ____ YES ____NO

Were you injured in any fall in the last year? (even a minor one) ____ YES ____ NO

Are you taking any medications? If yes, please list any medications, dosages, frequency and reason for taking medications below.

Medication	Dosage	Frequency	Began	Reason

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