PATIENT HEALTH QUESTIONAIRE

Name:_____ **DOB**_____ **SSN**_____

Referring Doctor:_____ **Date of last Dr. visit:**_____

Next Dr. appointment scheduled?_____ **height:**_____ **weight:**_____

Reason for therapy:_____ **Date symptoms began**?_____

Other therapy/treatment for this condition?_____

EMERGENCY NAME AND PHONE NUMBER_____

Please check yes or no for each question as it pertains to your medical history:

	Yes	No		Yes	No
Previous similar injury	☐	☐	Physical Therapy	☐	☐
High Blood Pressure	☐	☐	Kidney Problems	☐	☐
Cardiac Conditions/heart attack	☐	☐	Liver Problems	☐	☐
Fibromyalgia	☐	☐	Cancer	☐	☐
Lung problems	☐	☐	Lymes Disease	☐	☐
Circulation/ Blood Clots	☐	☐	Claustrophobia	☐	☐
Pacemaker	☐	☐	Mental Health Issues	☐	☐
Seizures	☐	☐	Vision Problems	☐	☐
Dizzy Spells/fainting/vertigo	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Metal Implants	☐	☐
Allergies/Asthma	☐	☐	Aids/HIV Positive	☐	☐
Fractures	☐	☐	Stroke	☐	☐
Arthritis	☐	☐	Could you be pregnant?	☐	☐

*Other conditions:*_____

Have you recently noted:

Nausea/ vomiting? ☐ Fatigue?☐ Weakness?☐ Fever/chills/sweats? ☐ Numbness or tingling?☐

Please list all surgeries, fractures, illnesses or injuries for which you have sought medical attention and the dates:_____

_____

_____

_____

Do you smoke?_____ Do you use street drugs?_____ which?_____

Do you drink alcohol?_____How many drinks/ week?_____

Please place a check next to any of the tests you have had for this condition: (give dates of test)

X-ray_____ CT scan_____ MRI_____ EMG_____ NCV_____

Myelogram _____Bone Scan _____ Other_____ (please describe)

Please list all medications that you are currently taking

(or provide a separate list and check here □)

Medication name: (include prescriptions, OTC, herbal and nutritional supplements)	***Dosage*** (amount)	***Frequency*** (how often)	***Route*** oral	sub-lin	inject	vapor	topical
			□	□	□	□	□
			□	□	□	□	□
			□	□	□	□	□
			□	□	□	□	□
			□	□	□	□	□
			□	□	□	□	□
			□	□	□	□	□

I agree to alert my therapist if there is any change to the above list at any time during my therapy. (please initial here) _____.

Are you allergic to any medications? Yes No *(please circle)* If yes, please list:_____

CIRCLE: Yes or No ** IMPORTANT: Are you currently receiving **ANY TYPE** of home care nursing, OT, Speech, PT, wound care or Any other Home Health care, Chiropractic or Acupuncture? (If "Yes" please discuss with our office **immediately. This would affect your insurance coverage here, as our office is unable to bill for services while receiving any of the above.**

Have you had any falls in the last 12 months? **Yes No** *(please circle)*

If so, how many?_____ Please describe the incident (s) and any injuries associated with the falls:_____

I certify that the above information is true and complete to the best of my knowledge:

Patient Signature_____ **Date**_____