Fredonia Physical Therapy, PLLC

Patient Health Questionnaire

Name: _____ **Age:** _____ **Date:** _____
What is your primary problem? _____
Date of Injury: _____

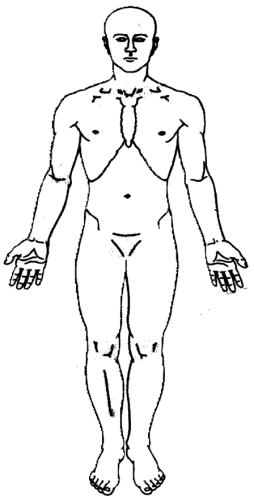
Describe Nature of Pain:

- ☐ **Constant (76-100%)**
- ☐ **Frequent (51-75%)**
- ☐ **Occasional (26-50%)**
- ☐ **Intermittent (25% or less)**

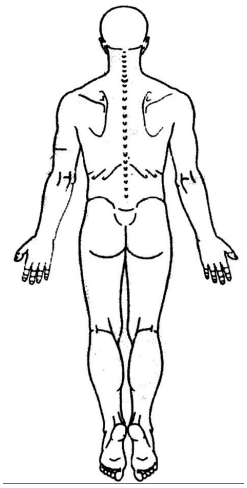
- ☐ **Sharp Pain** ////
- ☐ **Dull Pain** ++++
- ☐ **Throbbing** ΔΔΔΔ
- ☐ **Numbness** = = = =
- ☐ **Shooting** ••••
- ☐ **Burning** XXXX
- ☐ **Pins & Needles** 0000

Mark these drawings where you have pain or other symptoms with the symbols above:

Right



Left



Right

Intensity of pain at rest: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Intensity of pain with movement: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Since this condition began your symptoms have: ☐ Decreased ☐ Remained the Same ☐ Increased

Your symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night ☐ Increased during the day
☐ Same all day

Functional activities you're having difficulty with? _____

What do you hope to attain by attending therapy? _____

OVER ⇨

In the past have you been treated for the same problem? ☐ **Yes** ☐ **No**

If yes, whom did you see for that condition? ☐ **MD** ☐ **Physical therapist** ☐ **Occupational therapist**

☐ **Chiropractor** ☐ **Other** _____

When & what treatment did you receive? _____

Are you currently working? ☐ **Yes** ☐ **No** ☐ **N/A**
If not, are you off secondary to this injury? _____
Occupation: _____

Please list all current medications & dosages, including over-the-counter medications: _____
_____
_____
Any allergies: _____

Do you have a pacemaker or other implantable electronic device? _____
Do you exercise regularly? _____
For females, any chance you may be pregnant? _____

MEDICAL HISTORY:
Please circle any conditions of the following conditions that you have now and/or have had in the past. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

Angina or chest discomfort (413.9)
Arthritis (716.90)
Asthma (493.90)
Cancer: Location: _____ **Date:** _____
Diabetes (250.00)
Difficulty walking (781.2)
Drug (304.90) or alcohol (303.9) dependence
Epilepsy (345.90)
Fibromyalgia (729.1)
Heart attack (410.9)
Hepatitis (573.3)
Other: _____

High blood pressure (401.9)
Hip replacement (V43.64)
HIV/Aids (042)
Knee replacement (V43.65)
Obesity (278.00)
Osteoporosis (733.00)
Rheumatoid arthritis (714.0)
Stroke (434.91)
Systemic lupus (710.0)
Tobacco, Packs/Day:_____
Other: _____
Other: _____

Any recent hospitalizations or surgical procedures? _____
Any recent unusual weight gain or loss? _____

Patient Signature: _____ **Date:** _____

Therapist Signature – above information reviewed with patient:
_____ **Date:** _____