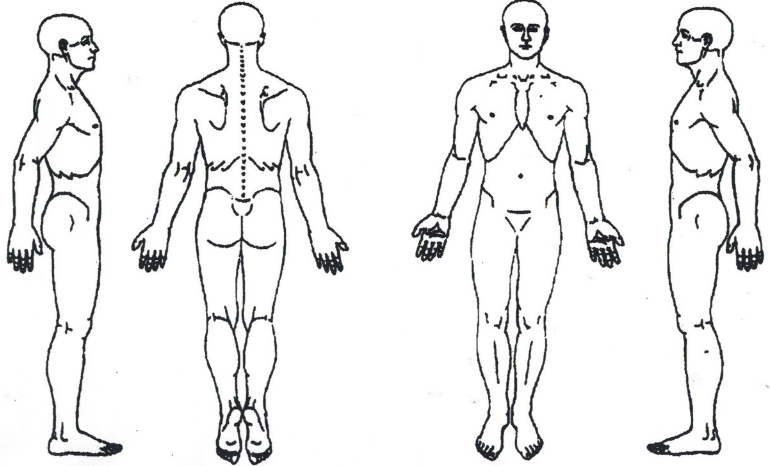
ABILITY PHYSICAL THERAPY - Patient Health Questionnaire PHQ

Patient Name: ____ Date: _____________

1. Describe you symptoms: ____
   When did your symptoms start?____
   How did your symptoms begin?____

2. How often do you experience your symptoms?
   1. Constantly (76-100% of the day)
   2. Frequently (51-75% of the day)
   3. Occasionally (26-50% of the day)
   4. Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
   1. Sharp 4. Shooting
   2. Dull Ache 5. Burning
   3. Numb 6. Tingling

4. How are your symptoms changing?
   1. Getting better
   2. Not changing
   3. Getting worse

5. Average intensity of your symptoms:

Last 24 Hours:	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
Last Week:	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)

6. How much has pain interfered with your normal work (including both work outside the home and housework)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

7. During the past four weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)
   1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

8. In general would you say your overall health now is…
   1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

9. Who have you seen for your symptoms:
   1. No one 2. Chiropractor 3. Medical doctor 4. Physical Therapist 5. Other:_________

   What treatment did you receive and when?____
   What tests have you had for your symptoms: 1. X-rays date:_____ 3. CT Scan date:_____
   2. MRI date:_____ 4. Other date:_____

10. Have you had similar symptoms in the past? Yes No

11. If you have received treatment in the past for the same or similar symptoms, who did you see?
    1. This office 2. Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

12. What is your occupation?
    ____
    1. Professional/Executive 4. Medical doctor 7. Retired
    2. White collar/secretarial 5. Homemaker 8. Other
    3. Tradesperson 6. Full-time student

13. If you are not retired, a homemaker, or a student, what is your current work status?
    1. Full-time 2. Part-time 3. Self-employed 4. Unemployed 5. Off work 6. Other

Family Doctor:________________________ Referring Doctor:____________________

Have you ever been diagnosed as having any of the following conditions? (Please circle/comment)

Y / N Cancer. If yes, describe what kind:______________
Y / N Heart Problems, Do you have a pacemaker? Yes / No
Y / N High blood pressure
Y / N Circulation problems
Y / N Kidney disease / Chronic bladder infection
Y / N Emphysema / Bronchitis
Y / N Chemical dependence (i.e. alcoholism)
Y / N Thyroid problems
Y / N Diabetes
Y / N Multiple Sclerosis
Y / N Rheumatoid Arthritis
Y / N Other Arthritis conditions:______________________
Y / N Gout
Other:____
Y / N Hepatitis
Y / N Tuberculosis
Y / N Stroke / TIA
Y / N Anemia
Y / N Asthma
Y / N Epilepsy
Y / N Pneumonia
Y / N Blood clots
Y / N Fibromyalgia
Y / N Ulcers
Y / N Headaches / Migraines
Y / N Urinary Incontinence
Y / N Osteoporosis
Y / N Depression

Do you use any assistive device in order to walk? YES / NO

During the past month, have you been feeling down, depressed, or hopeless? YES / NO

During the past month, have you been bothered by having little interest/pleasure in doing things? YES / NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES / NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES / NO

Please list any surgeries for which you have been hospitalized including the approximate date and reason:

Date	Reason for Surgery	Date	Reason for Surgery

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury.

Date	Injury	Date	Injury

List any allergies:____ Are you allergic to Latex? YES/NO

Which of the following over-the-counter medications have you taken in the last week? (please circle)

Aspirin   Tylenol   Advil/Motrin/Ibuprofen   Laxatives   Antacids
Decongestants   Antihistamines   Tagamet/Zantac/Pepcid   Vitamins/Mineral Supplements
Other:____

Please list any prescription medications you are taking (including pills, injections, and/or skin patches):

1.________________________ 3. ________________________ 5.________________________
2.________________________ 4.________________________ 6.________________________

What are your goals in coming for treatment?____
____

Have you recently noted:

Yes / No Weight loss/gain
Yes / No Weakness
Yes / No Numbness/tingling
Yes / No Nausea/vomiting
Yes / No Dizziness/lightheadedness
Yes / No Fever/Chills/Sweats