Patient Health Questionnaire

Name:_____**Occupation:** _____

Are you currently experiencing or do you have any of the following:

Allergies	□Yes	□No	Seizures	□Yes	□No
Anemia	□Yes	□No	Speech Problems	□Yes	□No
Anxiety or Panic Disorders	□Yes	□No	Stroke/TKA	□Yes	□No
Asthma	□Yes	□No	Thyroid Disease	□Yes	□No
Cancer	□Yes	□No	Tuberculosis	□Yes	□No
Site:_____			Vision Problems	□Yes	□No
Cardiac Conditions	□Yes	□No	Pacemaker	□Yes	□No
Chemical Dependency	□Yes	□No	Spinal Cord Stimulator	□Yes	□No
Cardiac Pacemaker	□Yes	□No	Lung Disease	□Yes	□No
Currently Pregnant	□Yes	□No	Blood Clots	□Yes	□No
Depression	□Yes	□No	Autoimmune Disease	□Yes	□No
Diabetes	□Yes	□No	Type:_____		
Dizzy Spells	□Yes	□No	Stomach Ulcers	□Yes	□No
Emphysema/Bronchitis	□Yes	□No	HIV	□Yes	□No
Fractures	□Yes	□No	Recent fever, chills, sweats	□Yes	□No
Gall Bladder Problems	□Yes	□No	Ringing in ears	□Yes	□No
Gastro Intestinal Disease	□Yes	□No	Hearing Loss	□Yes	□No
Heart Attack	□Yes	□No	Nausea Vomiting	□Yes	□No
Hepatitis	□Yes	□No	Headaches	□Yes	□No
Type:_____			Difficulty Swallowing	□Yes	□No
High Blood Pressure	□Yes	□No	Unexplained Weight Changes	□Yes	□No
Incontinence	□Yes	□No	Pain wakes me at night	□Yes	□No
Kidney Disease/Problems	□Yes	□No	Chest Pains - Angina	□Yes	□No
Metal Implants	□Yes	□No	Cough	□Yes	□No
Multiple Sclerosis	□Yes	□No	Shortness of Breath	□Yes	□No
Osteoporosis	□Yes	□No	Bowel or Bladder Disorder	□Yes	□No
Osteoarthritis	□Yes	□No			
Parkinson's	□Yes	□No	**Social History/ Wellness**		
Peripheral Vascular Disease	□Yes	□No	Do you drink alcoholic beverages?	□Yes	□No
Prosthesis/ Implants	□Yes	□No	Do you use tobacco?	□Yes	□No
Rheumatoid Arthritis	□Yes	□No	Do you exercise regularly?	□Yes	□No

Other medical illness: (Please list): _____

List current medications (including prescription, over-the-counter, and herbal):_____

List any known allergies (include medications, latex, etc): _____

List of previous hospitalizations/surgeries with approximate dates: _____

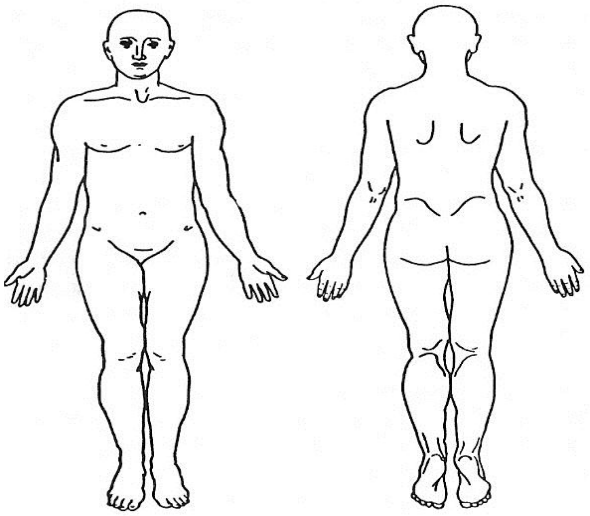
How often have you completed at least at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your conidition. □ At least 3 times week □ 1-2 times a week □ Seldom or Never

This is a statement other patients have made. "***I should not do physical activities which (might) make my pain worse***." Please rate your level of agreement with this statement below. (Circle number)

History of Current Problem or Symptom

0	1	2	3	4	5	6
Completely Disagree			Unsure			Completely Agree

Please mark on the diagram below to indicate where you feel symptoms. Use the following key to indicate the different types of symptoms.



Deep Ache = ZZZZ
Sharp/Stabbing = ////
Pins and needles = 0000
Burning = XXXX
Throbbing = ++++

Height:_____ Weight:_____

List the dates and results of any X-rays: _____
MRI: _____
Bone Density test: _____
Nerve Conduction test: _____
Other: _____

Do you have any regular numbness, tingling, or burning? □Yes □No If yes, where? _____

Please describe in detail your current problem and how this problem began: _____

_____

When did this problem first begin? (Approximate date): ____/_____/_____

Have you ever had this problem before? □Yes □ No

If you have, what treatment helped the most? _____

My pain/problem is slowly getting □worse □better □staying the same

My symptoms bother me: □constantly 100% □most of the time 75% □occasionally 50% □once in a while 25% or less

Are your symptoms worse in: □ Morning □ Afternoon □ Evening □ Night □ Same all day

What worsens your symptoms? _____

What makes your symptoms better?_____

On a scale from 0-10 (0 = no pain; 10 = worst pain imaginable), what is the **worst** your pain has been in the past several days? ___/10. What is the **best** your pain has been? ____/10.
Please rate your **current** pain on the line below.

0……..……5……10

How are you able to sleep at night? (Check one)
□Fine □Moderate difficulty □Only with medication □Change positions all night

PATIENT'S SIGNATURE: _____DATE: _____/_____/_____