Bright Bay Physical Therapy

PATIENT HEALTH QUESTIONAIRE

NAME:_____ DATE:_____ AGE: _____

1. Please describe your current complaint or limitation: _____

_____

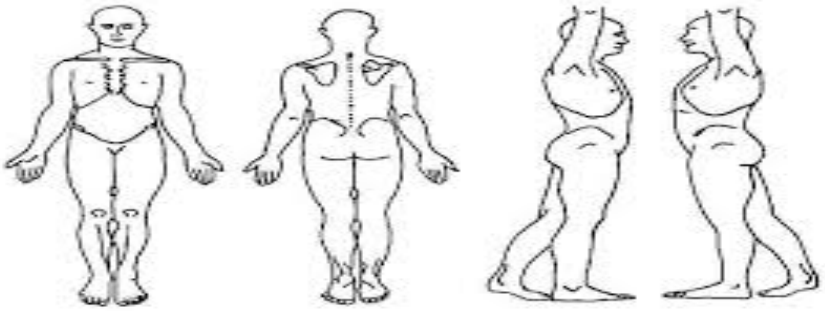
2. What is your goal for physical therapy: _____

What was your activity level prior to your injury? □ Sedentary □ Light Exercise □ Moderate Exercise □ Heavy Exercise

a. Please describe the nature of your pain (check all that apply):

__ Sharp Pain __ Dull (Pain) Ache __Throbbing __Numbness __Shooting __Burning __Tingling

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



MARK ON THIS PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

b. Indicate the intensity of your pain at rest: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Indicate the intensity of your pain with movement: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

c. What movement causes the pain to increase:_____

d. Since the condition began your symptoms have: ___ decreased ___ not changed ___ increased

e. Your symptoms are worse in: ___morning ___afternoon ___night ___increased during the day ___same all day

3. When did your problem begin: _____days ago _____months ago _____years ago, Date (if possible)_____

Describe how your problem began:_____

_____

Did you have surgery? ___Yes or ___No Date of Surgery:_____

Are you currently seeing any other health care provider for this condition?_____

4. In the past have you been treated for the same problem? ___Yes or ___No

If yes, who have you seen for that condition? __MD __Physical Therapist __Occupational Therapist __Chiropractor __Other

When and what treatment did you receive? _____

5. What makes your problem better? __Nothing __Lying down __Standing __Sitting __Movement/Exercise __Inactivity

6. What makes your problem worse? __Nothing __Lying down __Standing __Sitting __Movement/Exercise __Inactivity

7. For this condition, have you received any diagnostics? □ X-Rays □ MRI □ CT Scan □ Other _____

If yes, do you have results?_____

8. Since the onset of your current symptoms have you had: (check all that apply)

□ Any difficulty with control of bowel or bladder function
□ Any numbness in the genital or anal area
□ Weakness
□ Night pain / sweats
□ Problems with vision/hearing
□ Fevers / chills
□ Any dizziness or fainting attacks
□ Unexplained weight changes
□ Malaise (vague feeling of bodily discomfort)
□ Any sleep disturbance

9. Occupation_____ __FT or __PT Has your work status changed because of this condition? __Yes __No

10. What is your current work status? __FT, no restrictions __PT, no restrictions __Unemployed __Off work due to restrictions __FT, with restrictions __PT, with restrictions __FT Student __FT Homemaker __Retired

Present Weight: _____ Height: _____feet _____inches

Past Medical History

Have you ever had/been diagnosed with any of the following conditions? (check all that apply)

□ High Blood Pressure
□ Angina
□ Heart Attack
□ Stroke
□ Systemic Lupus
□ HIV/AIDS
□ MS
□ Parkinson's disease
□ Epilepsy
□ Diabetes
□ Rheumatoid Arthritis
□ Asthma
□ Hepatitis
□ Tumor
□ Head Injury
□ Circulatory / vascular problems
□ Depression
□ Anxiety
□ TMJ
□ Osteoporosis
□ GERD
□ Ulcerative Colitis
□ Concussion (how many)_____

□ Cancer, Location:_____ Date:_____
□ Osteoarthritis, Location:_____
□ Fractures_____
□ Pregnancy_____
□ Other_____
□ Tobacco #packs/day_____ □ Drug or Alcohol Dependence
□ Coffee/Tea/Caffeine drinks: Cups/cans per day_____

Please list all **medications/prescriptions** currently taking _____
_____
_____

Please list all **(OTC) over the counter medications and/or supplements** currently taking_____
_____

Please list all **allergies**: _____
_____

HOSPITLIZATION/SURGERIES

Month/Year	Hospital	Reason for Hospitalization

I certify that the above information is correct to the best of my knowledge. I will not hold Bright Bay PT responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature Date

_____

Reviewed by (PT) Date