



Professionally Staffed by New York Physical  
& Occupational Therapy, PLLC

## **PATIENT HEALTH QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

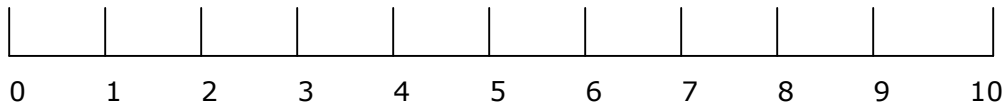
Please answer the following questions as completely as possible. The answers to this form will help your physical therapist better understand your medical concerns and conditions.

Please complete both the pain scale and the symptom drawing:

### **HOW BAD IS YOUR PAIN NOW?**

Please place an "X" on the line:

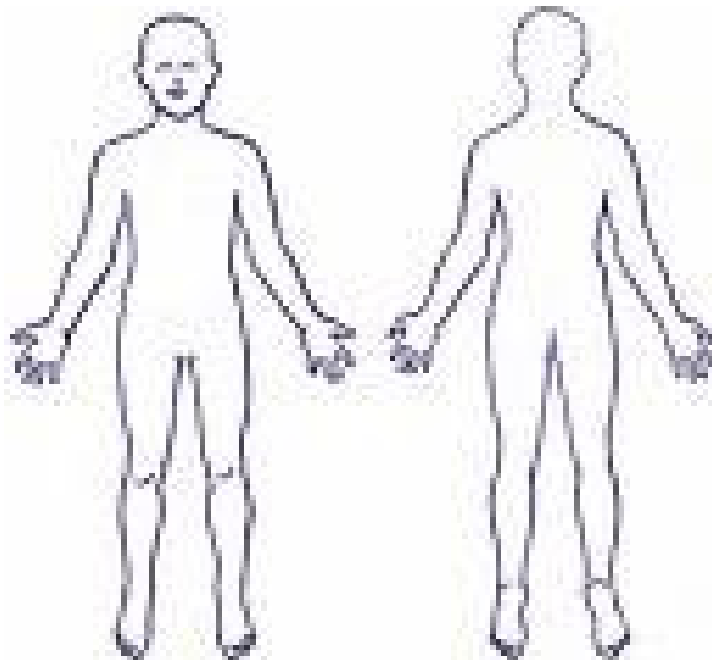
0 = No Pain, 10 = The Worst Pain Possible



### **WHERE IS YOUR PAIN NOW?**

Mark the areas on the body drawing where you feel the described sensations. Please use the appropriate symbols. Mark the areas of referred pain. Include all affected areas.

**Ache: ^^^^    Numbness: oooo    Burning: xxxx    Stabbing: ////    Pins & Needles: ====**



Name: \_\_\_\_\_

Referred to us by: \_\_\_\_\_  Doctor  Friend / Relative  Insurance Company

Have you ever had Physical Therapy for this condition? YES / NO If yes, when? \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right / Left / Ambidextrous Hand Dominant

Occupation / Previous Occupation: \_\_\_\_\_ Presently Working: YES / NO

Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_

**Do you engage in any of the following?**

	<b><u>YES</u></b>	<b><u>NO</u></b>		
Exercise / Sports:	<input type="radio"/>	<input type="radio"/>	Type / Frequency:	_____
Smoking:	<input type="radio"/>	<input type="radio"/>	Estimated Use:	_____
Alcohol:	<input type="radio"/>	<input type="radio"/>	Estimated Use:	_____
Coffee / Caffeine:	<input type="radio"/>	<input type="radio"/>	Estimated Use:	_____

**Medical History:**

If you check current or past, ***please comment.***

<b>Past or Current Medical Problems:</b>	<b><u>Current</u></b>	<b><u>Past</u></b>	<b><u>None</u></b>	<b><u>Comments</u></b>
<b>Cardiovascular:</b> (Heart Problems, High Blood Pressure, Pacemaker, Cardiac Surgeries, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____ _____
<b>Pulmonary:</b> (Asthma, Lung Disease, Breathing Disorder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____ _____
<b>Gastrointestinal:</b> (Stomach, Bowel, Intestinal, Celiac Disease, Food Allergies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____ _____
<b>Dermatologic:</b> (Skin Rashes, Psoriasis, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Genitourinary:</b> (Kidney Disease, Urinary Problems, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Ear, Nose &amp; Throat:</b> (Tonsils, Sinus, Swelling, Lumps)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Hematological:</b> (Anemia, Bleeding Disorders, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Immunologic Disord. / Infectious Disease:</b> (Tuberculosis, Hepatitis, HIV, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____

Name: \_\_\_\_\_

	<u>Current</u>	<u>Past</u>	<u>None</u>	<u>Comments</u>
<b>Endocrine / Metabolic:</b> (Diabetes, Thyroid, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Musculoskeletal:</b> (Bursitis, Osteoporosis, Osteopenia Tendonitis, Arthritis, Scoliosis, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____ _____
<b>Neoplastic Condition:</b> (Cancer, Tumors, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Neuropsychiatric:</b> (Depression, Seizures, Anxiety Disorder, Other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____
<b>Other:</b> (Woman's Health Issues, Fever Chills, Night Sweats, Heat / Cold Intolerance)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ _____ _____

**Please list any surgeries you have undergone with the dates:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list all Medications you are taking at this time:**

\_\_\_\_\_  
\_\_\_\_\_

**Please list any allergies you may have:**

\_\_\_\_\_  
\_\_\_\_\_

**Immediate family members who have:**

Diabetes	_____	Colon Cancer	_____
High Blood Pressure	_____	Prostate Cancer	_____
Heart Attack/Stroke	_____	Thyroid Disorder	_____
High Cholesterol	_____	Alcoholism	_____
Breast/Ovarian Cancer	_____	Depression/Suicide	_____
Dementia/Alzheimer's	_____	Other	_____

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

