ADVANCED PHYSICAL THERAPY OF VIRGINIA

Patient Health Questionnaire

Name: **Birth Date:** **Age:** **Height:** **Weight:**

Sex:
- ◯ M
- ◯ F

Do you smoke?
- ◯ Yes
- ◯ No

Are you:
- ◯ Right-handed
- ◯ Left-handed

No. of Children:

Occupation:

Currently Working? ◯ Yes ◯ No

Full-Time or Part-Time, light duty? ◯ Yes ◯ No

Do you live alone?
- ◯ Yes
- ◯ No

Does your home have:
- ☐ stairs with railing
- ☐ stairs without railing
- ☐ ramp
- ☐ uneven terrain
- ☐ assisting devices (bath)

Do you use (a):
- ☐ cane
- ☐ walker
- ☐ manual wheelchair
- ☐ Other
- ☐ motorized wheelchair
- ☐ glasses
- ☐ hearing aid(s)

Please rate your health:

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Have you had any major life changes during the past year (e.g., new baby, job change, death in the family)?

◯ Yes ◯ No

Family History (Please list any pertinent family history (e.g., heart disease, stroke, diabetes, cancer, etc.):

MEDICAL/SURGICAL HISTORY

A. Please check if you have ever had:

- ☐ Arthritis
- ☐ Blood disorder
- ☐ High blood pressure
- ☐ Diabetes/high blood sugar
- ☐ Multiple Sclerosis
- ☐ Seizures/Epilepsy
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Skin diseases
- ☐ Broken bones/fractures
- ☐ Circulation/vascular problems
- ☐ Lung problems
- ☐ Hypoglycemia/low blood sugar
- ☐ Muscular Dystrophy
- ☐ Allergies (Latex sensitivity?)
- ☐ Cancer (type) _____
- ☐ Repeated infections
- ☐ Depression
- ☐ Osteoporosis
- ☐ Heart problems/Pacemaker
- ☐ Stroke
- ☐ Head injury
- ☐ Parkinson disease
- ☐ Developmental problems
- ☐ Infectious disease (TB, Hep)
- ☐ Ulcers/stomach problems
- ☐ Other _____

B. Within the past year, have you had any of the following symptoms? Check all that apply:

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Coordination problems
- ☐ Weakness in arms or legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Unexplained weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Other _____

ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE?

◯ Yes ◯ No

Have you ever had surgery?

◯ Yes ◯ No

If Yes, please describe and include dates:

Describe the problem(s) for which you seek physical therapy:

Have you had this problem before?

◯ Yes ◯ No

If Yes, when?

Have you had physical or occupational therapy, chiropractic, or other treatment for this problem in the past?

◯ Yes ◯ No

If Yes, when?

When did the problem(s) begin (date)?

◯ Sudden ◯ Gradual onset

What happened?

Rate your discomfort on a scale from 0 (no pain) to 10 (worst pain):

What activities/positions make your problem WORSE?

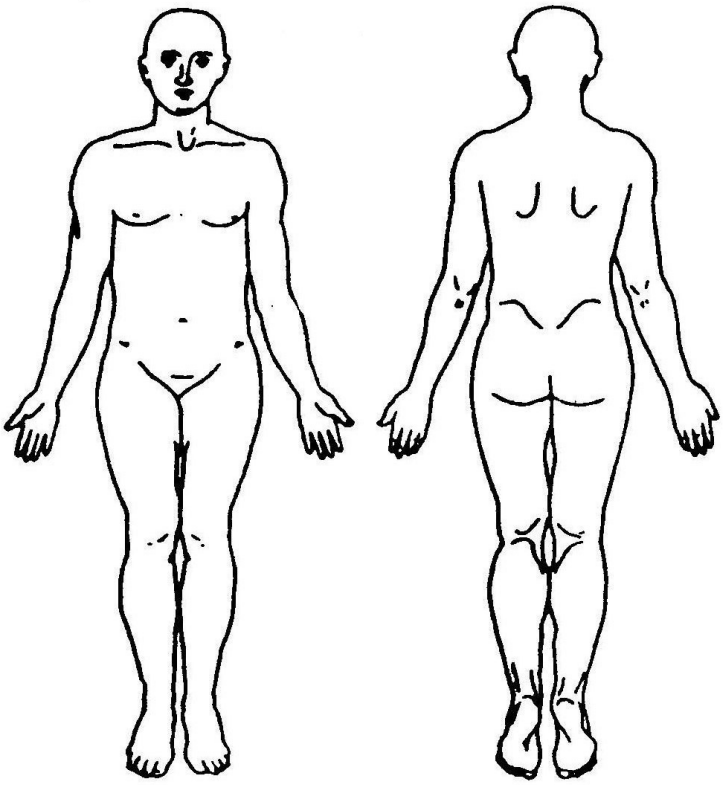
What activities/positions make your problem BETTER?

FUNCTIONAL ACTIVITIES

Do you have difficulty with any of the following :

- ☐ Moving in/out of bed
- ☐ Doing housework
- ☐ Exercising
- ☐ Self-care (bathing, dressing, eating, etc.)
- ☐ Prolonged sitting
- ☐ Walking
- ☐ Sleeping (due to this problem)

In the diagram below, please indicate areas of pain, tingling, numbness, burning, or “pins and needles.”



Special tests related to your current problem. Please give dates and results of X-rays, MRI, etc.:

Medications:

What are your goals for treatment?

Date of next doctor's appointment with referring physician:

FOR OFFICE USE ONLY

This patient is an **excellent / good / fair / poor** rehabilitation candidate for skilled physical therapy intervention.

Therapist's Signature _____ **Date** _____