

ADVANCED PHYSICAL THERAPY OF VIRGINIA, INC.
PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date of birth: _____ Age: _____

Sex: M / F Height: _____ Weight: _____ Right / Left Handed Children: _____ Do you smoke? Y / N

Occupation: _____ Currently Working Y / N Full Time or Part time, light duty? Y / N
Do you live alone? Y / N

Does your home have (circle): stairs no railing/ stairs with railing/ ramp/ uneven terrain/ assistive devices (bath).

Do you use (circle): cane/ walker/ manual wheelchair/ motorized wheelchair/ glasses/ hearing aids/ other _____

Please rate your health: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Have you had any major life changes during past year? (e.g. new baby, job change, death of a family member) Y N

Are you currently pregnant? Y / N

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:

- | | |
|--------------------------------------|---|
| 1. ___ Arthritis | 14. ___ Muscular Dystrophy |
| 2. ___ Broken bones/fractures | 15. ___ Parkinson disease |
| 3. ___ Osteoporosis | 16. ___ Seizures/epilepsy |
| 4. ___ Blood disorder | 17. ___ Allergies (Latex sensitivity?): _____ |
| 5. ___ Circulation/vascular problems | 18. ___ Developmental or growth problems |
| 6. ___ Heart problems/Pacemaker | 19. ___ Thyroid problems |
| 7. ___ High blood pressure | 20. ___ Cancer (type) _____ |
| 8. ___ Lung problems | 21. ___ Infectious disease (e.g. Tuberculosis, hepatitis) |
| 9. ___ Stroke | 22. ___ Kidney problems |
| 10. ___ Diabetes/high blood sugar | 23. ___ Repeated infections |
| 11. ___ Low blood sugar/hypoglycemia | 24. ___ Ulcers/stomach problems |
| 12. ___ Head injury | 25. ___ Skin diseases |
| 13. ___ Multiple Sclerosis | 26. ___ Depression |
| | 27. ___ Other: _____ |

ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? ___ YES ___ NO

b. Within the past year, have you had any of the following symptoms? (check that apply.)

- | | |
|---------------------------------|--------------------------------------|
| 1. ___ Chest pain | 13. ___ Difficulty sleeping |
| 2. ___ Heart palpitations | 14. ___ Loss of appetite |
| 3. ___ Cough | 15. ___ Nausea/vomiting |
| 4. ___ Hoarseness | 16. ___ Difficulty swallowing |
| 5. ___ Shortness of breath | 17. ___ Bowel problems |
| 6. ___ Dizziness or blackouts | 18. ___ Unexplained Weight loss/gain |
| 7. ___ Coordination problems | 19. ___ Urinary problems |
| 8. ___ Weakness in arms or legs | 20. ___ Fever/chills/sweats |
| 9. ___ Loss of balance | 21. ___ Headaches |
| 10. ___ Difficulty walking | 22. ___ Hearing problems |
| 11. ___ Joint pain or swelling | 23. ___ Vision problems |
| 12. ___ Pain at night | 24. ___ Other: _____ |

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 physical or occupational therapy, chiropractic, or other treatment for this problem in the past? YES / NO

When? _____ Sudden or Gradual Onset

What happened? _____

Have you ever had the problem(s) before? YES / NO When? _____

Severity of Discomfort (please circle the appropriate number) 0 1 2 3 4 5 6 7 8 9 10

No pain worst pain

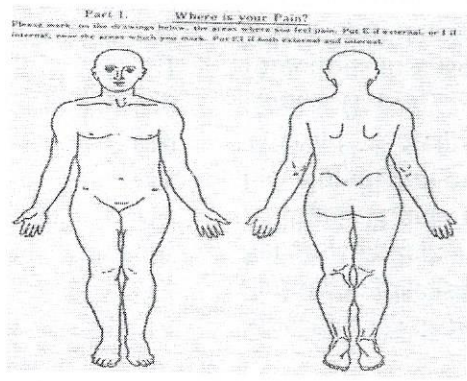
What activities or positions make your problem worse? _____

What activities or positions make your problem better? _____

Functional Activities

- Do you have difficulty moving in and out of bed? Y N
- Do you have difficulty with self-care (bathing, dressing, eating, toileting)? Y N
- Do you have difficulty with prolonged sitting (driving, work)? Y N
- Do you have difficulty with walking? Y N
- Do you have difficulty sleeping due to this problem? Y N

- Doing housework? Y N
- Exercising? Y N



Please indicate areas of pain, tingling, numbness, burning, pins and needles

Special tests: Related to your current problem. Please give dates and results.

X-rays: _____

MRI: _____

Other: _____

Medications: _____

What are your goals for treatment? 1. _____
2. _____

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 Signature _____

Date _____