Patient Health Questionnaire

Name: _____ **Occupation:** _____
Age: _____ **Height:** _____ft. _____in. **Weight:** _____lbs.

How did you hear about us? □ Commercial □ Physician □ Website □ Other Patient □ Other

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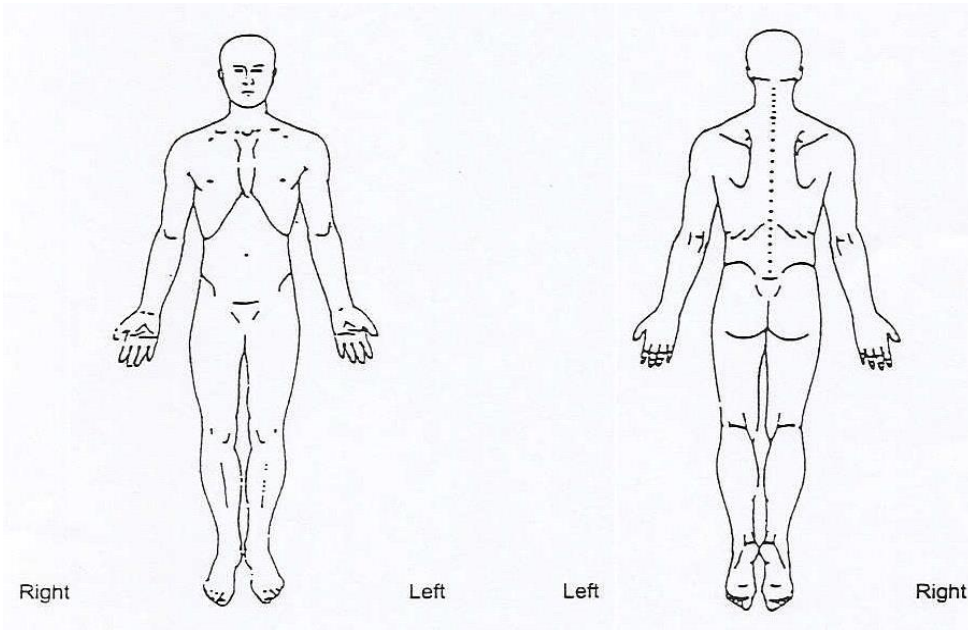
Are you currently receiving any Home Health services from Medicare? (i.e. nursing care, infusion, home health aide, therapy…) □ Yes □ No If yes what home care agency are you using? _____
Is an attorney handling your case? □ Yes □ No

Current Problem: Explain (what is bothering you?):_____
How did it happen? _____
Injury date or when did it start: / / Surgery Date: / /
What activities make your symptoms **worse**? _____
What activities make your symptoms **better**? _____
When are your problems most severe? □ Morning □ Afternoon □ Evening □ Consistent all day
Specifically, what are you not able to do because of your current problem?_____
_____
Have you had this problem before? □ Yes □ No If yes, then when _____
What treatment have you had for this **current** problem? □ None □ Surgery □ Injection □ Splint/Brace
□ Chiropractic treatment: # of visits: _____ □ Massage Therapy: # of visits: _____
□ X-rays/MRI etc: _____

Pain location/quality:
(indicate on diagram)

////////// Sharp pain/stabbing
^^^^^^ Dull / aching pain
+ + + + Pins and Needles
= = = = Numbness
xxxxxx Cramping
000000 Burning



Work: Are you currently out of work due to this problem? □ Yes □ No
Are you assigned to light duties? □ Yes □ No When do you intend to return to work? _____
Are you □ Right handed, □ Left handed?

Medical History:

□ Arthritis	□ Asthma	□ Emphysema	□ HIV	□ Cancer, type _____
□ Dizziness	□ Diabetes	□ Osteoporosis	□ AIDS	□ Heart Disease
□ Bronchitis	□ Hypoglycemia	□ Depression	□ Bowel and/or Bladder problems	
□ Strokes	□ Hypertension	□ Hearing problems	□ Unrelenting night pain	
□ Fever	□ Vision problems	□ Night sweats	□ Unexplained weight loss	
□ Migraines	□ Other: _____			

Please Complete Page 2

Previous procedures or surgeries: _____ Date: / /

_____ Date: / /

_____ Date: / /

Medications:
Please list all medications you are currently taking

Medication	**Dosage** Example: 20 mg	**Frequency** Example: twice a day	**How is it taken** Example: by mouth

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Social History:
Do you smoke? □ Yes □ No If yes, how much _____ per □ day □ week
Do you drink alcohol? □ Yes □ No If yes, how much _____ per □ day □ week □ month
Do you live: □ alone □ family □ friend □ spouse □ other _____
Do you have stairs and/or steps in your home? □ Yes □ No If yes, how many? _____

ACTIVITIES AND LIFESTYLE INDEX

The questions below concern your symptoms, medications, and daily activities. The information is not available from laboratory tests or x-rays, but only from you. Your answers in no way substitute for talking with your therapist, but highlight matters for review and provide long-term record of your status at this time. Please try to answer each question exactly as you think or feel. There are no right or wrong answers. Thank you.

PATIENT NAME:_____

Please check (√) the **ONE** best answer for the questions below

Over the past week, are you able to:	Without Any Difficulty (3)	With Some Difficulty (5)	With Much Difficulty (7)	Unable to Do (9)
Dress yourself including tying shoelaces & doing buttons				
Get in/out of bed				
Get in/out of car				
Ascend/descend stairs or curbs				
Walk outdoors on flat ground				
Perform personal hygiene				
Bend down to pick up items from floor				
Sitting more than 30 minutes				
Complete daily activities outside the home (i.e.: shopping, driving, yard work, etc.)				

How much pain have you experienced over the past week? Please circle the number that shows how much pain you had during the last week.

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Severe pain)

Which of the following best describes today? Please check (√) only one.

__ I can do everything I want to do.

__ I can do most of the things I want to do, but have some limitations

__ I can do some of the things I want to do, but have many limitations.

__ I can hardly do anything I want to do

How do you feel today compared to one month ago. Please check (√) only one

__ MUCH BETTER today than one month ago.

__ A LITTLE BETTER today than one month ago.

__ About THE SAME as one month ago.

__ A LITTLE WORSE today than one month ago.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Fit for Life Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that upon request I may be provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that I may revoke this consent in writing, except to the extent that Fit for Life has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Fit for Life may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity or family member, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date

_____

Witness