Outpatient Rehabilitation
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Garnet Health
MEDICAL CENTER

Patient Health Questionnaire

Name: _____ Date: _____ Age: _____

1. Please describe your current complaint or limitation (Why you need therapy): _____

_____

When did your problem begin (onset date/accident date)? _____

2. Have you recently had surgery? ___ Yes ___ No Types and Dates: _____

_____

3. What is your goal for therapy? _____

4. **Past Medical History:** Please mark if you have or have not had any of the following:

Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Stroke
___	___	Heart Attack/Angina	___	___	HIV/AIDS
___	___	Asthma/Breathing Problems	___	___	Hepatitis
___	___	Systemic Lupus	___	___	Rheumatoid Arthritis
___	___	Epilepsy/Seizures	___	___	Depression
___	___	Arthritis/Osteoarthritis	___	___	Tuberculosis (TB)
___	___	Kidney Disease	___	___	Latex Allergy
___	___	Pacemaker/Metal Implants	___	___	Allergies: _____
___	___	Congestive Heart Failure	___	___	Pregnancy
___	___	Recent unexplained weight loss	___	___	Other: _____
___	___	Diabetes: ___ Insulin ___ Non-insulin dependent			
___	___	Cancer – location: _____ Date: _____			

Do you have a permanent disability rating? ___ Yes ___ No

5. Please list any medications you are presently taking: _____

_____

6. Have you had physical therapy or other treatment in the past for this same problem? __Yes __No

Explain and list dates: _____

7. Please list any x-rays or tests recently performed and the results: _____

_____

8. Marital status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widow(er)

9. Patient lives with: ___ Self ___ Spouse ___ Children ___ Other _____

10. Have you had any recent life changes or losses? ___ Yes ___ No

11. Do you have any financial concerns that may affect your choices in care/treatment? __Yes __No

(Please turn over and complete next page)

Patient name _____

12. Occupation: _____

Has your work status changed because of this condition? ___ Yes ___ No

Current work status:

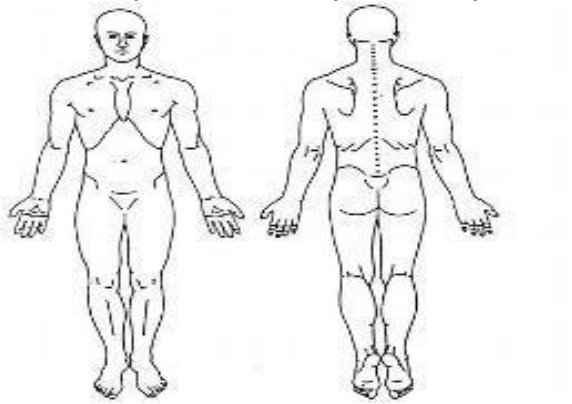
___ FT, no restrictions
___ FT, with restrictions
___ Off work due to restrictions
___ Full time student
___ Full time homemaker
___PT, n o restrictions
___ PT, with restrictions
___ Retired
___ Unemployed

13. Is your injury as a result of an accident? ___ Yes ___ No

14. Is there currently any legal action being pursued? ___ Yes ___ No

15. If patient is a child, has your child been immunized? ___ Yes ___ No

16. Mark on picture where you have pain or other symptoms.



17. Indicate the intensity of your pain at rest.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

18. Indicate the intensity of your pain with movement.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

19. Please describe the nature of your pain:

___ Sharp pain
___ Dull (pain) ache
___ Throbbing
___ Numbness
___ Shooting
___ Burning
___ Tingling
___ Constant (76-100%)
___ Frequent (51-75%)
___ Occasional (26-50%)
___ Intermittent (25% or less)

20. What makes your pain/problem worse? _____

21. What makes your pain/problem better?_____

22. Have you altered your ways of dressing, bathing, or doing household tasks because of this condition? ___ Yes ___ No

23. Have you altered your recreational activities/hobbies because of this condition? ___ Yes ___ No

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*******To be completed by Therapist*******

Health history reviewed by: _____

Variances Noted: _____