Montefiore

Patient Name: _____ MRN: _____

Patient D.O.B.: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE

Occupation: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Leisure Activities / Hobbies: _____

Are you? ☐ Right-handed ☐ Left-handed

Where do you live? ☐ Private Home ☐ Apartment / Rented Room ☐ Assisted Living / Group Home
☐ Hospice ☐ Other: _____

With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others
☐ Child ☐ Other: _____

Does your home have? ☐ Stairs, NO Railing ☐ Stairs, Railing
☐ Ramps ☐ Uneven Terrain

Please Explain: _____

How many times have you fallen in the past 12 months? _____ Did it result in an injury? ☐ Yes ☐ No

Do you have a fear of falling? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

General Health Status ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below.

_____

Have you had Physical Therapy treatment since January of this year? ☐ No ☐ Yes # of Visits: _____

Have you had Chiropractic treatment since January of this year? ☐ No ☐ Yes # of Visits: _____

Have you had Home Healthcare in the last 30 days? ☐ No ☐ Yes

If yes, Home Healthcare Provider: _____

SURGERY / HOSPITALIZATION (including date and reason)

_____ _____

_____ _____

CURRENT MEDICATIONS (including prescription, over the counter, and herbal)

You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route
			☐ Oral ☐ Patch ☐ Topical ☐ Other:
			☐ Oral ☐ Patch ☐ Topical ☐ Other:
			☐ Oral ☐ Patch ☐ Topical ☐ Other:
			☐ Oral ☐ Patch ☐ Topical ☐ Other:
			☐ Oral ☐ Patch ☐ Topical ☐ Other:

Provider (print name): _____ Date: _____

Signature / Credentials: _____ Time: _____ AM / PM

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CURRENT CONDITION

When did this problem(s) first begin / date of onset? _____

If chronic, when did you seek medical treatment? _____

Is your condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery: _____

Describe the problem(s). _____

Explain how the problem(s) occurred. _____

Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times: _____

Are your symptoms worse in: ☐ Morning ☐ Afternoon

☐ Evening ☐ Night ☐ Same All Day

How are you taking care of the problem(s) now? _____

What is your current pain level (0 – 10; 0 no pain) _____

My pain / problem is slowly getting: ☐ Worse ☐ Better ☐ Staying the Same

My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%)

☐ Occasionally (50%) ☐ Once in a While (25%)

Do you have any numbness, tingling or burning? ☐ Yes ☐ No

If yes, please check one: ☐ Constantly ☐ Intermittently

What functions could you perform before, that you are now unable to do?

_____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.

_____

Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.

_____

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

If yes, please tell us what it is: _____

What are you goals for therapy? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING

Nausea or Vomiting	☐ Yes	☐ No	Chest Pains (Angina)	☐ Yes	☐ No
Productive/Chronic Cough	☐ Yes	☐ No	Pain Wakes Me at Night	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No	Recent Fever, Chills, Sweats	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Difficulty Sleeping	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Visual Problems	☐ Yes	☐ No	Heart Palpitations	☐ Yes	☐ No
Hearing Loss/Ringing in Ears	☐ Yes	☐ No	Loss of Appetite	☐ Yes	☐ No
Difficulty Walking	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Unusual Weakness	☐ Yes	☐ No	Fatigue or Myalgia	☐ Yes	☐ No
Joint Pain or Swelling	☐ Yes	☐ No	Unexplained Weight Changes	☐ Yes	☐ No

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HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

Allergies	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Hepatitis, If Yes, Type:	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No	Kidney Disease/Problems	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Spinal Cord Stimulator	☐ Yes	☐ No
Bowel or Bladder Disorder	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Cancer, If yes, Site:	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cardiac Conditions	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	Peripheral Vascular Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Auto Immune Disease	☐ Yes	☐ No	Fractures	☐ Yes	☐ No
If yes, Type: _____					

SOCIAL HISTORY / WELLNESS

Do you drink alcoholic beverages?	☐ Yes	☐ No	Do you use tobacco?	☐ Yes	☐ No

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

☐ At least 3 times per week ☐ 1-2 times per week ☐ seldom or never

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

_____ _____

Patient / Guardian Signature Date

Provider (print name): _____ Date: _____

Signature / Credentials: _____ Time: _____ AM / PM