Patient Health Questionnaire

Name _____________________________________ **Date** ________________________

Describe your current injury or limitation: ___________________________________
____

When did your problem begin? (specific date if possible) ________________________

What was the cause of your injury or limitation? ______________________________
____

Describe the location of your pain: ____
____

Describe the nature of your pain:

- ☐ sharp pain
- ☐ dull ache
- ☐ throbbing
- ☐ numbness
- ☐ shooting
- ☐ burning
- ☐ tingling
- ☐ tightness/ tension

- ☐ constant
- ☐ frequent
- ☐occasional
- ☐ intermittent

Indicate the intensity of your pain on a scale of 1-10 with 0 being no pain and 10 being the worst pain:

At rest: ______ With movement: ______ Average: _______ Maximum: _______

Are your symptoms worse in ☐ morning ☐ afternoon ☐ night ☐ same all day **?**

What is your sleeping position? ☐ side ☐ back ☐ stomach ☐ varied

How many hours of sleep do you get per night? ______________________________

What activities make your problem better? __________________________________
____

What activities make your problem worse? __________________________________
____

 Name ______________________

Please describe your occupation and the nature of your daily activity (i.e. sitting at computer most of day, full time mother lifting/ holding child, student….)

____

____

Are you currently doing any types of exercise, movement? Please describe type and frequency. Also explain if you were exercising previous to your injury and if that has changed.

____

____

____

Have you been receiving any other forms of treatment for your current condition?

____

Have you had any diagnostic tests for this condition? If so, please describe and give results:

____

Please provide past medical history (surgeries, falls, other conditions, even from childhood). ____

____

____

____

Are you currently taking any medications?__________________________________

____

Please provide emergency contact information:

Name ______________________________

Relationship _________________________

Phone ______________________________