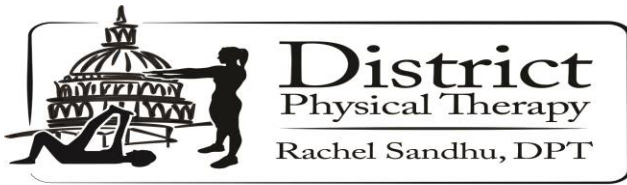

Patient Health Questionnaire

Please answer the following health related questions to the best of your knowledge to help your physical therapist better guide your treatment.

Do you have any past medical injuries or surgeries? If so, please describe and when it occurred:

What activities do you enjoy and what helps you relieve stress?

Are you taking any current medications or herbal supplements?

Do you drink caffeine beverages or coffee? If so, how many cups per day?

Do you drink alcohol or smoke? If so, how often?

Have you ever been diagnosed with any of the following conditions? ***FILL IN THE CIRCLE***

	NO	YES (within the last 12 months)	YES (diagnosed > 1 year ago)
1. Lung Cancer	O	O	O
2. Breast Cancer	O	O	O
3. Prostate Cancer	O	O	O
4. Colon Cancer	O	O	O
5. Skin Cancer	O	O	O
6. Bone Cancer	O	O	O
7. Leukemia Cancer	O	O	O
8. Lymphoma Cancer	O	O	O
9. Other Cancer: (list)		O	O
____________________			
____________________		O	O

	NO	YES
10. Chronic Urinary or Bladder Infections (3 or more within last year)	O	O
11. Pneumonia	O	O
12. Bone or Joint Infections	O	O
13. Pelvic Inflammatory Disease	O	O
14. Kidney Infection	O	O
15. Other Infection (list)		
____________________	O	O
____________________	O	O
16. Heart Attack	O	O
17. Heart Valve Problems	O	O
18. Blood Clots in Legs (DVT's)	O	O
19. Artery Blockage in Legs	O	O
20. High Blood Pressure	O	O
21. Stroke: Mini-Stroke	O	O
Transient Ischemic Attack	O	O
22. Anemia / Low Blood Levels	O	O

	NO	YES
23. Asthma	O	O
24. Emphysema	O	O
25. Alcoholism	O	O
26. 26. Depression	O	O
27. Tuberculosis	O	O
28. Hypothyroid (low)	O	O
29. Hyperthyroid (high)	O	O
30. Diabetes	O	O

31. Diabetes- if yes, when were you diagnosed? ___________________

	NO	YES
32. Multiple Sclerosis	O	O
33. Rheumatoid Arthritis	O	O
34. Degenerative (wear & tear) Osteoarthritis	O	O
35. Gout	O	O
36. Anklyosing Spondylitis	O	O
37. Hepatitis	O	O
38. Stomach Ulcers	O	O
39. Epilepsy / Seizures	O	O
40. Headaches (> 1/week)	O	O
41. Endometriosis	O	O
42. Urinary Incontinence	O	O
43. Osteoporosis	O	O

44. Please mention any other conditions:

____

____

____

____
Physical Therapist Signature Date

____
Patient Signature Date