ez rehab
physical therapy, inc.

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PATIENT HEALTH QUESTIONNAIRE

Name (please print): _____

Onset/Injury Date: _____

Type of Injury/Condition: _____

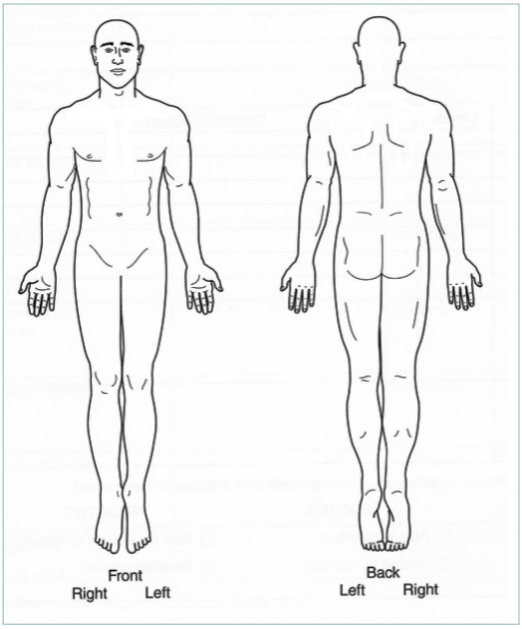
Type of Surgery / Date: _____

Next Doctor's Appointment: _____

Describe previous treatment for this condition: _____

_____

Indicate areas of current symptoms



List of recent diagnostic studies:

[ ] X-ray
[ ] MRI
[ ] CT Scan
[ ] Doppler
[ ] Ultrasound
[ ] Other _____

Indicate any of the following changes in your health:

[ ] Weight Loss/Gain
[ ] Weakness
[ ] Pregnant/IUD
[ ] Pain at Night
[ ] Fever/Chills/Sweat
[ ] Headaches
[ ] Cramps in Legs when Walking
[ ] Fatigue
[ ] Numbness/Tingling
[ ] Change in Vision or Hearing
[ ] Insomnia

Indicate if you had or have any of the following:

[ ] Surgeries
[ ] Sprains/Strains
[ ] Heart Problems
[ ] Circulation
[ ] Problems/Clots
[ ] Easy Bruising/Bleeding
[ ] Indigestion/Heart-burn
[ ] Loss of Consciousness
[ ] Diabetes
[ ] Cancer
[ ] Asthma/Breathing Problems
[ ] Leg/Ankle Swelling
[ ] Fainting
[ ] Fractures
[ ] Blood Pressure Problems
[ ] Motor Vehicle Accident
[ ] Lung Disease
[ ] Urinary Problems/Infections
[ ] Allergies/Skin Sensitivity

Explain and give approximate dates for any items listed above: _____

_____

List any previous injury that may affect current care: _____

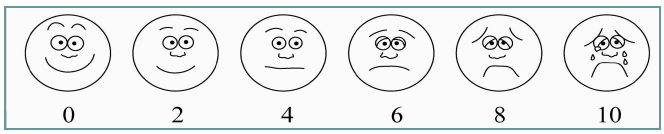
List of Current Medications: _____

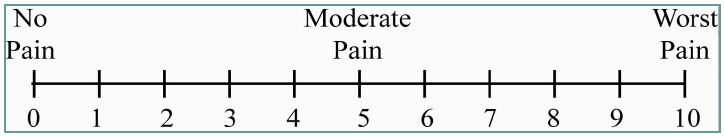
_____

Type of Pain: [ ] Sharp/Shooting [ ] Burning [ ] Aching [ ] Tingling / Numbness [ ] Other: _____

RATE YOUR PAIN (1 = MINIMAL 10 = SEVERE)

AT ITS WORST: 1 2 3 4 5 6 7 8 9 10 **AT ITS BEST**: 1 2 3 4 5 6 7 8 9 10





What are your rehabilitation or fitness goals? _____

Is there anything else you would like to include or ask your therapist? _____

Patient/Personal Representative Signature: _____ Date: