JAMES RIVER PHYSICAL THERAPY

PATIENT HEALTH QUESTIONNAIRE

Name:_____ **Age:**_____

1. For which problem(s) are we seeing you today?_____
2. When did your symptoms start?_____
3. Are you taking any medications for this condition?_____
4. Since your problem(s) started, are your symptoms getting: Better Worse Not Changing
5. Do your symptoms vary over a 24 hour period? How?_____
6. What activities increase your symptoms?_____
7. What activities decrease your symptoms?_____
8. Have you had any x-rays, MRI, or CT tests done for your current diagnosis?_____If yes, please describe:_____
9. What do you do for exercise and how often?_____
10. Have you recently noticed any of the following?

	Yes	No		Yes	No
Unexplained Weight Loss/Gain			Fever, Chills, Sweat		
Nausea/Vomiting			Fainting Spells		
Unexplained Fatigue/Weakness			Bowel or Bladder Problems		

11. Have you been diagnosed with any of the following conditions?

	Yes	No		Yes	No
High Blood Pressure			Rheumatiod Arthritis		
Diabetes			Osteoporosis		
Heart Problems			Seizures		
Kidney Problems			Cancer		
Dizziness			Multiple Sclerosis		
Asthma			Hepatitis/Tuberculosis (circle)		
Breathing Difficulties			Frequent Falls		
Thyroid Problems			Headaches		
Stroke			Other:		

12. Any allergies to latex, adhesives, or medications?_____
13. Please list any previous surgeries, fractures, or serious injuries with approximate dates:_____
14. Do you have any metal implants in your body (pins/plates, pacemaker)?_____
15. For women: Are you pregnant? Yes No If yes, how many months?_____
16. Is the problem you are being treated for involved in litigation (lawsuit)? Yes No