BECK PHYSICALTHERAPY, P.C.

PATIENT HEALTH QUESTIONNAIRE

Name:__________________________ Date:__________ Height/Weight ____________

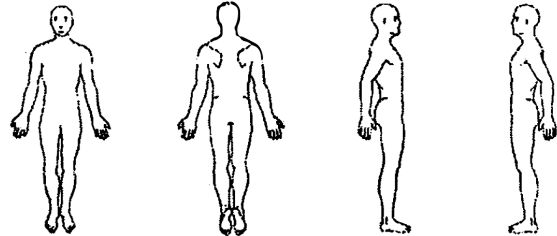
Please describe your current complaint or limitation: ______________________________

What is your goal for therapy ______________________________

Please circle the best description that relates to the nature of your pain:

Sharp pain
Dull/ache
Throbbing
Numbness
Shooting
Burning
Tingling

Constant (76-100%)
Frequent (51-75%)
Occasional (26-50%)
Intermittent (25% or less)



(Mark on the where you have pain or other symptoms)

Indicate the intensity of your pain at rest: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Indicate the intensity of your pain with movement: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

What movement causes the pain to increase? ______________________________

Since this condition began, your symptoms have: ◊ decreased ◊ not changed ◊ increased

Your symptoms are worse in: ◊ morning ◊ afternoon ◊ night ◊ increased during the day ◊ same all day

When did your problem begin: _____ days ago/months ago/years ago specific day _____/_____/_____

Describe how your problem began: ______________________________

Did you have surgery? ◊ Yes ◊ No Date of surgery ___/___/___

Did you/are you receiving any type of home health care? ______________________________

Have you had ANY prior physical therapy THIS year? ______________________________

In the past, have you been treated for the same problem? ◊ Yes ◊ No

What makes your problem better? ◊ Nothing ◊ Lying down ◊ Standing ◊ Sitting ◊ Movement/Exercise ◊ Inactivity

What makes your problem worse? ◊ Nothing ◊ Lying down ◊ Standing ◊ Sitting ◊ Movement/Exercise ◊ Inactivity

Occupation: ______________________ ◊ F/T ◊ P/T

Has your work status changed because of this condition? ◊ Yes ◊ No

What is current work status? _______ Any restrictions/limitations at work? ______________________

Medications? If yes, please list: ______________________________

Past or present medical history: ______________________________