Patient Health Questionnaire

Adirondack Physical Therapy and Sports Rehabilitation, PC

Patient Name: ______________________________ **Today's Date**________________

Age______ **Height**_______ **Weight**________ **Occupation** ______________________

What is your chief complaint? (diagnosis, symptoms or condition)

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1. **Do you now have or have you ever had?**
   - ☐ Dizziness/ fainting/ seizures
   - ☐ Numbness/weakness/tingling
   - ☐ Shortness of breath
   - ☐ Fever/chills
   - ☐ Recent unexplained weight loss or gain
   - ☐ Poor circulation
   - ☐ Bruising
   - ☐ Artificial joint replacement: type________________
   - ☐ Cancer : type ______________________________
   - ☐ Heart condition/pacemaker
   - ☐ High blood pressure ☐ Low blood pressure
   - ☐ Chest pain
   - ☐ Diabetes: type__________________________
   - ☐ Arthritis ______osteo ______rheumatoid _______other
   - ☐ Tuberculosis/hepatitis _______/HIV
   - ☐ Emphysema
   - ☐ Asthma
   - ☐ COPD (lung disease)
   - ☐ Thyroid disease
     ☐Hypo ☐Hyper
   - ☐ Kidney /Liver disease
   - ☐ Osteoporosis
   - ☐ Stroke
   - ☐ Fibromyalgia
   - ☐ Bladder incontinence
   - ☐ Bowel incontinence
   - ☐ Visual impairment
   - ☐ Hearing impairment
   - ☐ Depression
   - ☐ Anxiety
   - ☐ Other ________________
2. **Are you pregnant?** ☐ **YES** ☐ **NO**
3. **Do you smoke?** ☐ **YES** ☐ **NO**
4. **Does pain awaken you at night?** ☐ **YES** ☐ **NO**
5. **What tests have you had for this problem?**

   ☐ **MRI** ☐ **x-ray** ☐ **CT scan** ☐ **blood work** ☐ **EMG** ☐ **other**________________
6. **Please list any surgeries you have had:** ______________________________________

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7. **Have you fallen in the last year?** ☐**YES** ☐**NO**

   Have you had more than one fall in the last year? (even a minor one)

   ☐**YES** ☐**NO**

   Were you injured in any fall in the last year? (even a minor one)

   ☐**YES** ☐**NO**

8. **Are you currently taking any medications?** If yes, please list below or provide a list of prescriptions, over the counter medications, herbals, vitamins and supplements

Medication	Dosage	Frequency	How Administered?	Reason

Options for how medications are administered – (therapist can assist with this)		
Oral (by mouth)	Injection	Sublingual (under tongue)
Nasal	Opthalmic (Eye)	
Topical	Otic (Ear)	

INFORMED CONSENT

I hereby desire to engage in, voluntarily or under the orders of a physician, physician assistant or other health care provider, the evaluation and treatment of my condition at Adirondack Physical Therapy and Sports Rehabilitation, PC.

______________________________ ______________________

Signature of Patient **Date**

______________________________ ______________________

Guardian Signature (if under 18 y/o) **Date**