Patient Health Questionnaire

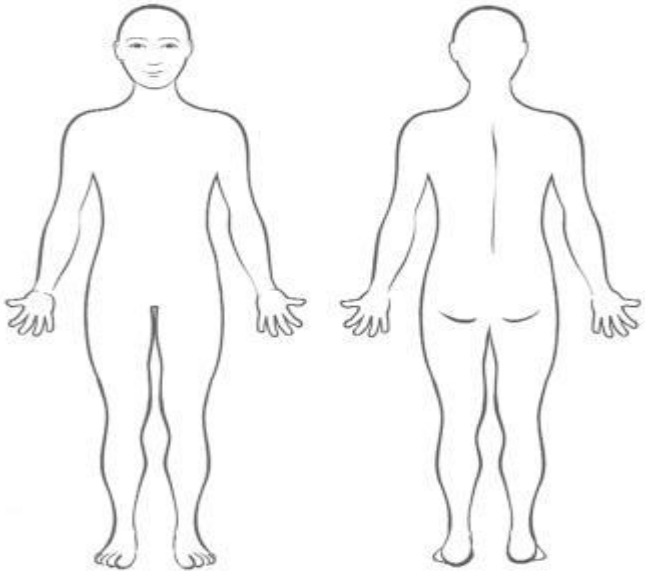
1. Name _____
2. Height/Weight _____
3. What is your age? _____ Date of Birth: _____
4. Hand Dominance ☐ R ☐ L
5. Please list all current prescriptions (OTC, herbals, vitamins/minerals/dietary with name/dosage/frequency and route of administration) _____

   _____
6. What is your occupation? _____
7. Do you currently have a diagnosis? _____
8. Have you ever received physical therapy for current diagnosis? _____
9. Where is your pain/problem? _____
10. What caused your pain/problem? _____
11. Approximately when did it start? _____
12. Have you ever had this pain/problem before? ☐ Yes ☐ No
13. On the scale below circle your average pain level in the past couple of days:

Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

14. Draw your pain in the diagram below. Circle areas of tingling or numbness.



15. Please indicate when your pain is the greatest (AM, PM, Middle of night)? _____

16. Have you recently taken steroids or ANTICOAGULANTS?_____

17. What aggravates your symptoms (movements, positions, etc.)

_____

18. What eases your symptoms (movements, positions, meds, etc.)

_____

19. What activities are you limited in or unable to perform due to your condition? _____

_____

20. Do you exercise? ☐ Yes ☐ No

Type_____Frequency_____

21. List recent diagnostic studies: (X-Rays, MRIs, etc.) _____

_____

22. Do you have METAL (pins, plates, pacemaker) anywhere in your body? _____

23. For women: are you pregnant? ☐ Yes ☐ No Months of pregnancy_____

24. Have you noticed a recent unexplained weight loss or gain? ☐ Yes ☐ No

25. Have you ever had or been diagnosed with: (check box by all that apply)

Asthma		Diabetes		Bone or Joint Disease		Other (list)	
Allergies		Heart Disease		Auto-immune disease			
Stroke		Lung Disease		Depression			
Seizures		Kidney Disease		Cancer (type)			
Heart Attack/ Angina		Liver Disease		Blood clot			
High Blood Pressure		Thyroid Disease		Lymphedema			

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do herby agree and give consent for Forward Motion Physical Therapy, Inc to furnish medical care and treatment necessary in treating his/her physical condition.

⇒_____ _____

Signature of Patient/Guardian **Date**

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Forward Motion Physical Therapy, Inc. A photo copy of this assignment is information necessary including Medical records, to secure payment.

⇒_____ _____

Signature of Patient/Guardian **Date**

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Forward Motion Physical Therapy, Inc to obtain any and all medical records concerning my case from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize Forward Motion Physical Therapy, Inc to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time.

⇒_____ _____

Signature of Patient/Guardian **Date**