GREATERTHERAPYCENTERS

PATIENT HEALTH QUESTIONNAIRE

DATE: _____ NAME: _____

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

□ PRIVATE HOME OR APT. □ ASSISTED LIVING OR GROUP HOME □ LONG-TERM CARE FACILITY
□ OTHER _____

WHO DO YOU LIVE WITH? (CHECK ALL THAT APPLY)

□ ALONE □ SPOUSE/SIGNIFICANT OTHER □ CHILD/CHILDREN □ GROUP SETTING
□ PERSONAL CARE ATTENDANT □ OTHER _____

DOES YOUR OCCUPATION PRIMARILY INVOLVE?

□ SITTING AT A COMPUTER OR PROLONGED COMPUTER USE
□ MANUAL LABOR □ RETIRED
□ HOMEMAKER □ OTHER
□ HOMEMAKER WITH SMALL CHILDREN

EMPLOYMENT/WORK STATUS (CHECK ALL THAT APPLY)

□ FULL-TIME, OUTSIDE HOME □ FULL-TIME, IN HOME
□ PART-TIME, OUTSIDE HOME □ PART-TIME, IN HOME
□ WORKING WITH MODIFICATION BECAUSE OF CURRENT INJURY
□ NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY
□ UNEMPLOYED □ RETIRED
□ OTHER _____

WHAT ARE YOUR HOBBIES AND ARE YOU ABLE TO CURRENTLY PARTICIPATE AT THE LEVEL AND FREQUENCY YOU WOULD LIKE?

_____

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES OR PROVIDE A LIST TO YOUR THERAPIST:

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

_____

ARE YOU A DIABETIC? □ YES □ NO DO YOU HAVE A PACEMAKER? □ YES □ NO
IF YES, FOR HOW LONG? _____

ARE YOU PREGNANT? □ YES □ NO
IF YES, HOW MANY MONTHS? _____

DO YOU USE A? (CHECK ALL THAT APPLY)

□ CANE □ WALKER/ROLLING WALKER/ROLLATOR □ MANUAL WHEELCHAIR □ MOTORIZED WHEELCHAIR
□ OTHER _____

If yes to any of the above, what condition necessitates the use of assistance? _____

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITION
(DO NOT INCLUDE THE CONDITION YOU ARE HERE FOR)

_____

HAVE YOU RECEIVED PREVIOUS PHYSICAL OR OCCUPATIONAL THERAPY? □ YES □ NO
If yes, for what condition and what did you like/dislike about the treatment?

_____

DO YOU CURRENTLY HAVE A FAMILY PHYSICAL THERAPIST? □ YES □ NO

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

□ EXCELLENT □ GOOD □ FAIR □ POOR

GREATERTHERAPYCENTERS

PATIENT HEALTH QUESTIONNAIRE

QUESTIONS 1-12 ARE FOR PATIENTS WHO RECENTLY HAD SURGERY AND ARE HERE FOR POST-SURGICAL REHABILITATION. IF YOU HAVE NOT HAD SURGERY PLEASE GO TO THE NEXT SECTION OF QUESTIONS

1 DATE OF SURGERY: _____/ _____/ _____

2 TYPE OF SURGERY: _____

3 DESCRIBE YOUR SYMPTOMS PRIOR TO SURGERY:

_____

_____

_____

4 HOW DID YOUR SYMPTOMS BEGIN PRIOR TO SURGERY?

_____

_____

5 NATURE OF SYMPTOMS:

SINCE SURGERY

- □ SHARP
- □ BURNING
- □ DULL ACHE
- □ TINGLING
- □ NUMB
- □ SHOOTING

PRIOR TO SURGERY

- □ SHARP
- □ BURNING
- □ DULL ACHE
- □ TINGLING
- □ NUMB
- □ SHOOTING

6 HOW OFTEN ARE SYMPTOMS EXPERIENCED?

SINCE SURGERY

- □ CONSTANTLY (76-100% OF DAY)
- □ FREQUENTLY (51-75% OF DAY)
- □ OCCASIONALLY (26-50% OF DAY)
- □ INTERMITTENTLY (0-25% OF DAY)

PRIOR TO SURGERY

- □ CONSTANTLY (76-100% OF DAY)
- □ FREQUENTLY (51-75% OF DAY)
- □ OCCASIONALLY (26-50% OF DAY)
- □ INTERMITTENTLY (0-25% OF DAY)

7 SINCE YOUR SURGERY WOULD YOU REPORT THAT YOUR SYMPTOMS ARE:

□ BETTER □ WORSE □ SAME □ IMPROVING

8 WHAT IS YOUR AVERAGE PAIN INTENSITY?

LAST 24 HOURS/PAST WEEK/LAST 4 WEEKS (CIRCLE ONE)

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

9 HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK, HOBBIES OR DAILY ACTIVITIES?

SINCE SURGERY □ NOT AT ALL □ A LITTLE BIT □ MODERATELY □ QUITE A BIT □ EXTREMELY

PRIOR TO SURGERY □ NOT AT ALL □ A LITTLE BIT □ MODERATELY □ QUITE A BIT □ EXTREMELY

10 PRIOR TO SURGERY, WHO DID YOU SEE FOR YOUR SYMPTOMS?

□ NO ONE □ CHIROPRACTOR □ MEDICAL DOCTOR □ PHYSICAL THERAPIST

□ OTHER _____

11 WHAT TREATMENT DID YOU RECEIVE PRIOR TO YOUR SURGERY AND WHEN (APPROXIMATELY)?

_____

12 PRIOR TO SURGERY WHAT TESTS DID YOU HAVE?

□ XRAYS □ MRI □ CT SCAN □ OTHER _____

GREATERTHERAPYCENTERS

PATIENT HEALTH QUESTIONNAIRE

QUESTIONS 13-21 ARE FOR PATIENTS WHO ARE HERE AS A RESULT OF AN INJURY OR CONDITION

13 DESCRIBE YOUR CURRENT SYMPTOMS: _____

_____

_____

14 DID YOUR SYMPTOMS BEGIN AS A RESULT OF A SPECIFIC INJURY OR GRADUAL ONSET?

□ INJURY □ GRADUAL ONSET EXPLAIN: _____

15 HOW OFTEN ARE SYMPTOMS EXPERIENCED?

- □ CONSTANTLY (76-100% OF DAY)
- □ FREQUENTLY (51-75% OF DAY)
- □ OCCASIONALLY (26-50% OF DAY)
- □ INTERMITTENTLY (0-25% OF DAY)

16 WHAT IS YOUR AVERAGE PAIN INTENSITY?

LAST 24 HOURS/PAST WEEK/LAST 4 WEEKS (CIRCLE ONE)

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

17 HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK, HOBBIES OR DAILY ACTIVITIES?

- □ NOT AT ALL
- □ A LITTLE BIT
- □ MODERATELY
- □ QUITE A BIT
- □ EXTREMELY

18 HOW ARE YOUR SYPTOMS CHANGING?

- □ IMPROVING
- □ NOT CHANGING
- □ WORSE

19 WHO HAVE YOU SEEN FOR YOUR INJURY OR SYMPTOMS?

□ NO ONE □ CHIROPRACTOR □ MEDICAL DOCTOR □ PHYSICAL THERAPIST

□ OTHER _____

20 WHAT TREATMENT DID YOU RECEIVE FOR YOUR INJURY OR SYMPTOMS AND WHEN (APPROXIMATELY)?

_____

_____

21 WHAT TESTS HAVE YOU HAD RELATED TO YOUR INJURY OR SYMPTOMS?

□ XRAYS □ MRI □ CT SCAN □ OTHER _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND ACCURATE

SIGNATURE: _____ DATE: _____