

Buffalo Back & Neck Physical Therapy, P.C.

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PATIENT HEALTH QUESTIONNAIRE

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME: _____ DATE: _____

LEISURE ACTIVITIES: _____

OCCUPATION: _____

ALLERGIES: List any medication(s) you are allergic to:

Are you latex sensitive? Yes No List any other allergies we should know about

Please check () any of the following whose care you're under

_____ Physician (MD / DO)	_____ Psychiatrist / Psychologist
_____ Dentist	_____ Chiropractor
_____ Physical Therapist	_____ Other _____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

Have you EVER been diagnosed as having any of the following conditions?

() YES () NO Cancer. If YES, describe what kind: _____	() YES () NO Rheumatoid arthritis
() YES () NO Heart problems	() YES () NO Alcoholism
() YES () NO High blood pressure	() YES () NO Other arthritic conditions
() YES () NO Circulation problems	() YES () NO Depression
() YES () NO Asthma	() YES () NO Hepatitis
() YES () NO Emphysema/Bronchitis	() YES () NO Tuberculosis
() YES () NO Chemical dependency	() YES () NO Stroke
() YES () NO Thyroid problems	() YES () NO Kidney disease
() YES () NO Diabetes	() YES () NO Anemia
() YES () NO Multiple sclerosis	() YES () NO Other (specify) _____
() YES () NO Epilepsy	

In the past month have you been feeling down, depressed or hopeless? () YES () NO

In the past month have you been bothered by having little interest or pleasure in doing things? () YES () NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? () YES () NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? () YES () NO

Please list any **surgeries or other conditions for which you have been hospitalized**, including the approximate date and reason for the surgery or hospitalization:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Please describe any **significant injuries for which you have been treated** (including fractures, dislocations, and sprains) and the approximate date of injury:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

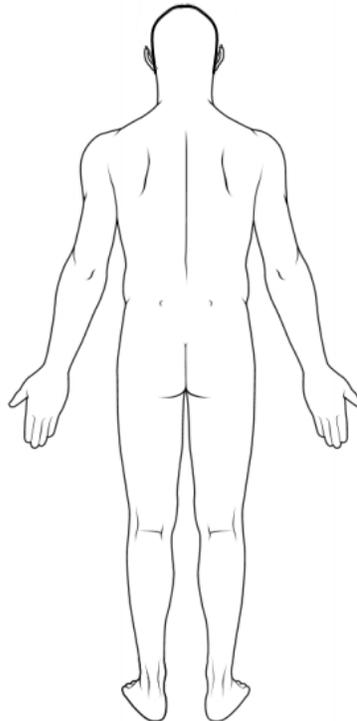
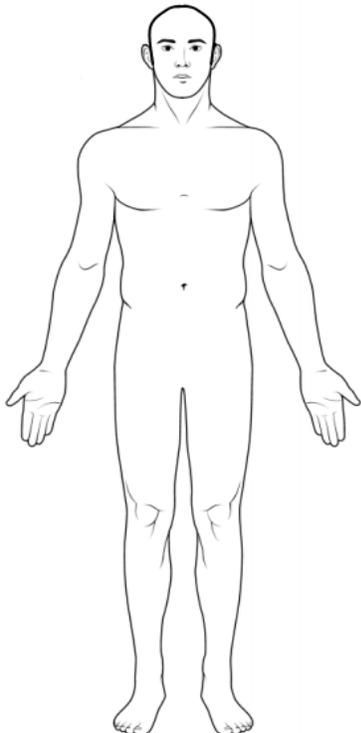
- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Aspirin | <input type="checkbox"/> YES <input type="checkbox"/> NO Tylenol |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Advil/Aleve | <input type="checkbox"/> YES <input type="checkbox"/> NO Vitamins/mineral supplements |
| Other _____ | |

Please list any **PRESCRIPTION** medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 7. _____ |
| 3. _____ | 4. _____ | 8. _____ |
| 5. _____ | 6. _____ | 9. _____ |

Have you recently noted:

- | | |
|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO weight loss/gain | <input type="checkbox"/> YES <input type="checkbox"/> NO weakness |
| <input type="checkbox"/> YES <input type="checkbox"/> NO nausea/vomiting | <input type="checkbox"/> YES <input type="checkbox"/> NO fever/chills/sweats |
| <input type="checkbox"/> YES <input type="checkbox"/> NO fatigue | <input type="checkbox"/> YES <input type="checkbox"/> NO numbness or tingling |



Please use the diagram to the left to indicate the location of your complaints. Use the key below to identify the nature of your symptoms

XXXX	-	Pain
OOOO	-	Numbness
////////	-	Tingling