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 Heart problems | ( )YES ( )NO Rheumatoid arthritis |
| ( )YES ( )NO High blood pressure | ( )YES ( )NO Alcoholism |
| ( )YES ( )NO Circulation problems | ( )YES ( )NO Other arthritic conditions |
| ( )YES ( )NO Asthma | ( )YES ( )NO Depression |
| ( )YES ( )NO Emphysema/Bronchitis | ( )YES ( )NO Hepatitis |
| ( )YES ( )NO Chemical dependency | ( )YES ( )NO Tuberculosis |
| ( )YES ( )NO Thyroid problems | ( )YES ( )NO Stroke |
| ( )YES ( )NO Diabetes | ( )YES ( )NO Kidney disease |
| ( )YES ( )NO Multiple sclerosis | ( )YES ( )NO Anemia |
| ( )YES ( )NO Epilepsy | ( )YES ( )NO Other (specify)__________________ |

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. ______________________

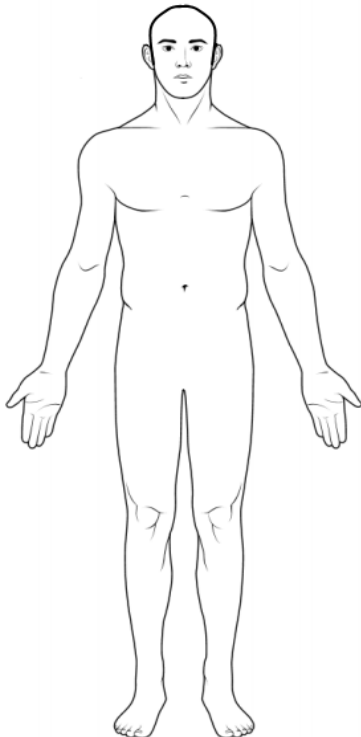
Please describe any **significant injuries for which you have been treated** (including fractures, dislocations, and sprains) and the approximate date of injury:

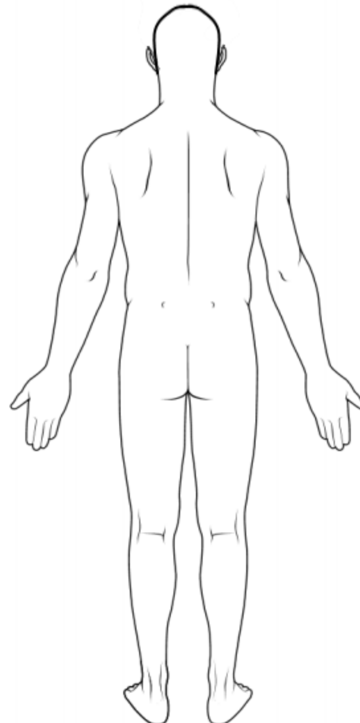
1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

Which of the following OVER-THE-COUNTER medications have you taken in the last week?
( )YES ( )NO Aspirin ( )YES ( )NO Tylenol
( )YES ( )NO Advil/Aleve ( )YES ( )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:
( )YES ( )NO weight loss/gain ( )YES ( )NO weakness
( )YES ( )NO nausea/vomiting ( )YES ( )NO fever/chills/sweats
( )YES ( )NO fatigue ( )YES ( )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