FULL CIRCLE
PHYSICAL THERAPY

Patient Health Questionnaire

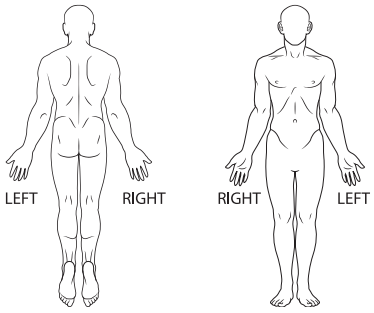
PATIENT NAME: _____ **DATE:** _____

1. Describe your current problem: _____

2. If your problem is painful, please fill out the following pain scale:	PAIN SCALE: Please rate your pain on the scale below: 0 no pain, 10 the worst pain imaginable										
	At Worst	0	1	2	3	4	5	6	7	8	9	10
	Current	0	1	2	3	4	5	6	7	8	9	10
	At Best	0	1	2	3	4	5	6	7	8	9	10

3. Was the pain **gradual** or **sudden?** (circle one)

4. Please mark areas where you feel pain or symptoms on the body below:



What makes your symptoms better?

1 _____
2 _____
3 _____

What makes your symptoms worse?

1 _____
2 _____
3 _____

7. What do you think caused your symptoms? _____

8. How often do you experience your symptoms? (circle one)

☐ **Constantly** (76%-100% of the time) ☐ **Frequently** (51%-75% of the time) ☐ **Occasionally** (26%-50% of the time) ☐ **Intermittently** (0%-25% of the time)

9. Are your current symptoms (select one): ☐ **Improving** ☐ **Worsening** ☐ **Staying the Same**

10. What treatment have you received so far for this problem? (chiropractic, injections, etc.) _____

_____

11. Have you ever had this problem before? ☐ **Yes** ☐ **No** (select one) When? _____

_____

Previous Treatment: _____

_____

_____

It is important to us to understand some specific things about your health. Please check the box for all that apply:

Have you **RECENTLY** noted any of the following?

- ☐ Difficulty maintaining walking balance
- ☐ Changes in bowel or bladder function
- ☐ Dizziness/lightheadedness
- ☐ Fever /chills/sweats
- ☐ Shortness of breath
- ☐ Changes in health
- ☐ Changes in appetite
- ☐ Nausea/Vomiting
- ☐ Weight loss/gain
- ☐ Pain at night
- ☐ Incontinence
- ☐ Headaches
- ☐ Weakness
- ☐ Diarrhea
- ☐ Numbness/Tingling
- ☐ Difficulty Swallowing
- ☐ Fatigue
- ☐ Falls
- ☐ Constipation

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Have you **EVER** been diagnosed with any of the following conditions?

- ☐ Bloodborne pathogen
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Circulation problems
- ☐ Depression
- ☐ Kidney Problems
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Lung problems/asthma
- ☐ Allergies:
- ☐ Liver Problems
- ☐ Chest pain/Angina
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Stroke
- ☐ Blood Clots
- ☐ Ulcers
- ☐ Osteoarthritis/other arthritic condition
- ☐ Other _____
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Cancer

Do you smoke? ☐ Yes ☐ No If yes, how much do you smoke? _____
Are you sensitive to latex? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Any recent falls? ☐ Yes ☐ No When? _____
How many falls in the past 12 months? _____
Any injuries related to falls? ☐ Yes ☐ No If so, what injuries? _____
During the past month have been feeling down, depressed or hopeless? ☐ Yes ☐ No
During the past month have you been bothered by having little interest in doing things? ☐ Yes ☐ No

Please List any **SURGERIES** or other conditions for which you have been hospitalized including the approximate date and reason

Date	Surgery

Please list any **INJURIES** for which you have been treated, including approximate date (including fractures, sprains, and dislocations)

Date	Injury

Medications List
Please check which **over the counter medications** you have taken in the last week:

- ☐ Aspirin
- ☐ Advil/Ibuprofen
- ☐ Other:
- ☐ Tylenol/Acetaminophin
- ☐ Decongestants
- ☐ Antacids
- ☐ Acid Reducer
- ☐ Vitamin/Minerals:
- ☐ Aleve/Naproxen
- ☐ Antihistamine

Please list all **Prescription Medications** you have taken in the last week

Medication	Dosage	Frequency	Method of delivery (oral, injection, etc.)

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