Joints In Motion Physical Therapy

Patient Health Questionnaire

Name:________________________________Date:________________________________

How did you hear about us?____

DOB:________________________Referring Physician:____________________________

Area of injury or problem:__________________Have you had these symptoms before? YES NO

How long have you had your present symptoms?__________________Date of Injury:__________

Please check the item below that applies to the cause of your symptoms:

_____ Work Related Injury Name of Employer________________________________

_____ Motor Vehicle Accident _____ Recurrence of Previous Injury _____Cause Unknown

_____ Athletic/Recreational Injury _____ Other ________________________________

Please circle all the following which you now have or have ever had:

Allergies	Dizziness	High Blood Pressure	Paralysis
Arthritis	Fainting Spells	Low Blood Pressure	Positive HIV/AIDS
Asthma	Frequent Headaches	High Blood Sugar	Seizures
Backaches	Frequent Urination	Low Blood Sugar	Shortness of Breath
Cancer or Tumors	Fractures	Metal Implants	Tuberculosis (TB)
Chest Pains	Hepatitis	Operations/Surgeries	Unusual Bleeding Tendencies
Current Infection	Hernia	OB/GYN Problems	Are You Pregnant?
Diabetes	Heart Disease/Attack	Pacemaker	Other____________

Are you presently taking any medication? YES NO Please List:________________________

____

Please list activities you have difficulty with due to your current problem:

____

Have you ever received physical therapy before? YES NO If yes, explain why, when, where:

____

I certify that I have answered all the above questions to the best of my ability and will update my therapist if changes occur in my health.

Signature Date