North End
PHYSICAL THERAPY

PATIENT HEALTH QUESTIONNAIRE

Patient Full Name

Today's Date

Age | Date of Birth | Height | Weight

Occupation

Are you currently working? ☐ Yes ☐ No

Date Last Worked

Referring Provider | Phone

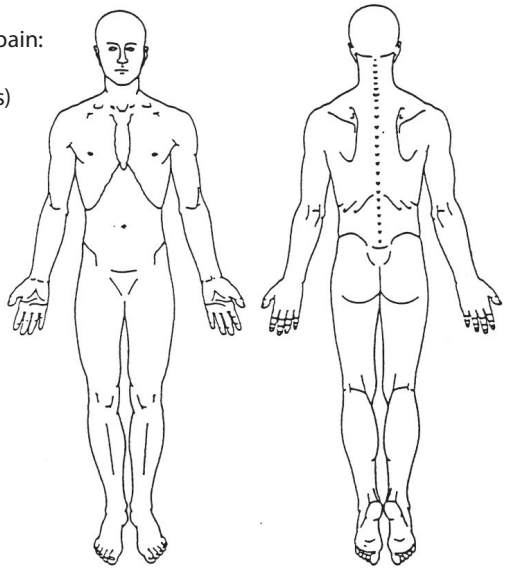
Date of last physical exam?

What is the reason for today's visit / diagnosis?

Date of injury

If known, what is the cause of injury?

Mark location(s) of pain:



Check which word(s) best describe your pain:

- ☐ sharp
- ☐ dull
- ☐ achy
- ☐ throbbing
- ☐ numb
- ☐ tingling
- ☐ occasional
- ☐ intermittent
- ☐ frequent
- ☐ constant

Describe your pain / symptoms in space below:

Rate your level of pain on a scale of 1 to 10:

No Pain ⟶ Worst Pain Ever Felt

At best, pain is: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At worst, pain is: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On average, pain is: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have numbness / tingling?

☐ Yes ☐ No If yes, where?

Do you have nausea or dizziness?

☐ Yes ☐ No If yes, please explain:

Does sneezing / coughing make your symptoms worse?

☐ Yes ☐ No

What makes your symptoms worse?

What makes your symptoms better?

Does pain disrupt your ability to sleep at night?

☐ Yes ☐ No If yes, how often do you wake due to pain?

Before this episode / incident, had you ever had similar symptoms?

☐ Yes ☐ No If yes, please explain:

Please describe previous treatment(s) for similar symptoms:

Are you currently receiving any other treatment for this condition?

☐ Yes ☐ No If yes, what type & how often:

Have you had any special tests?

☐ X-Ray ☐ MRI ☐ CAT ☐ EMG ☐ Other