ADVANCED PHYSICAL THERAPY OF VIRGINIA, INC
PATIENT HEALTH QUESTIONNAIRE

Name: _____Date of birth: _____Age: _____

Sex: M / F Height: _____ Weight: _____ Right / Left Handed Children: ____ Do you smoke? **Y / N**

Occupation: _____ Currently Working **Y / N** Full Time or Part time, light duty? **Y / N**
Do you live alone? **Y / N**
Does your home have (circle): stairs no railing/ stairs with railing/ ramp/ uneven terrain/ assistive devices
Do you use (circle): cane/ walker/ manual wheelchair/ motorized wheelchair/ glasses/ hearing aids/ other _____

Please rate your health: ___ Excellent ___ Very Good ___ Good ___Fair ___ Poor

Have you had any major life changes during the past year? (e.g. new baby, job change, death of a family member) **Y N**
Are you currently pregnant? **Y / N**
Family History: Please list any pertinent family history (e.g. heart disease, stroke, diabetes, cancer, etc.)
_____

Medical/Surgical History

a. Please check if you have ever had:

1. ___Arthritis
2. ___Broken bones/fractures
3. ___Osteoporosis
4. ___Blood disorder
5. ___Circulation/vascular problems
6. ___Heart problems/Pacemaker
7. ___High blood pressure
8. ___Lung problems
9. ___Stroke
10. ___Diabetes/high blood sugar
11. ___Low blood sugar/hypoglycemia
12. ___Head injury
13. ___Multiple Sclerosis
14. ___Muscular Dystrophy
15. ___Parkinson disease
16. ___Seizures/epilepsy
17. ___Allergies (**Latex sensitivity?): _____**
18. ___Developmental or growth problems
19. ___Thyroid problems
20. ___Cancer (type)_____
21. ___Infectious disease (e.g. Tuberculosis, hepatitis)
22. ___Kidney problems
23. ___Repeated infections
24. ___Ulcers/stomach problems
25. ___Skin diseases
26. ___Depression
27. ___Other: _____

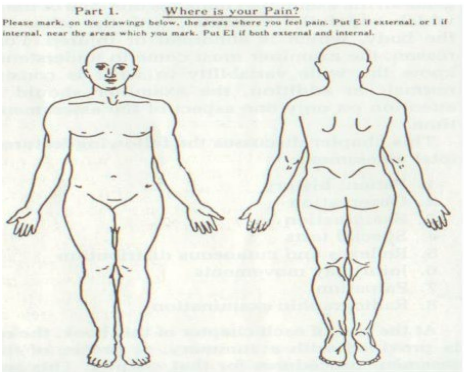
ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? ____ YES ____ NO

b. Within the past year, have you had any of the following symptoms? (check all that apply.)

1. ___ Chest pain
2. ___ Heart palpitations
3. ___ Cough
4. ___ Hoarseness
5. ___ Shortness of breath
6. ___ Dizziness or blackouts
7. ___ Coordination problems
8. ___ Weakness in arms or legs
9. ___ Loss of balance
10. ___ Difficulty walking
11. ___ Joint pain or swelling
12. ___ Pain at night
13. ___ Difficulty sleeping
14. ___ Loss of appetite
15. ___ Nausea/vomiting
16. ___ Difficulty swallowing
17. ___ Bowel problems
18. ___ Unexplained weight loss/gain
19. ___ Urinary problems
20. ___ Fever/chills/sweats
21. ___ Headaches
22. ___ Hearing problems
23. ___ Vision problems
24. ___ Other: _____

Have you ever had surgery? **YES / NO**
If yes please describe, and include dates: _____
_____
Describe **the problem(s)** for which you seek physical therapy_____
_____
Have you had physical or occupational therapy, chiropractic, or other treatment for this problem in the past? **YES / NO**
When?_____
When did the problem(s) begin (date)? _____ Sudden or Gradual Onset
What happened? _____
Have you ever had the problem(s) before? **YES / NO** When? _____
Severity of Discomfort (please circle the appropriate number) 0 1 2 3 4 5 6 7 8 9 10
No pain worst pain
What activities or positions make your problem worse?_____
What activities or positions make your problem better?_____

Functional Activities
Do you have difficulty moving in and out of bed? **Y N** Doing housework? **Y N**
Do you have difficulty with self-care (bathing, dressing, eating, toileting)? **Y N** Exercising? **Y N**
Do you have difficulty with prolonged sitting (driving, work)? **Y N**
Do you have difficulty with walking? **Y N**
Do you have difficulty sleeping due to this problem? **Y N**



Please indicate areas of pain, tingling, numbness, burning, pins and needles

Special tests: Related to your current problem. Please give dates and results.
X-rays: _____
MRI: _____
Other: _____
Medications: _____
_____
What are your **goals** for treatment? 1. _____
2. _____
Date of next doctor's appointment with referring physician:_____
_____
FOR OFFICE USE ONLY
This patient is an **excellent/good/fair/poor** rehabilitation candidate for skilled physical therapy intervention.

Therapist Signature _____ **Date**_____