PATIENT HEALTH QUESTIONNAIRE
Rehabilitation Services

Patient Name: _____ Date: _____

What problem are we seeing you for today? _____

Are you currently receiving therapy services? ☐ Yes ☐ No

If yes, please explain: _____

Have you had therapy treatment for your current condition in the past? ☐ Yes ☐ No

If yes, when and where? _____

LANGUAGE

Do you need an interpreter? ☐ Yes ☐ No Preferred Language: _____

Are you hard of hearing? ☐ Yes ☐ No Are you blind/low vision? ☐ Yes ☐ No

PAIN

On a scale of 1 to 10, how would you rate your level of pain? At worst: _____ At best: _____

Where do you feel your pain? _____

How would you describe it? (Ex: sharp, dull, burning, numb, etc.) _____

HISTORY

Do you have, or have you had, any of the following? Please check all that apply.

- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyositis
- ☐ Fractures
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Kidney Problem
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Nervous Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant (currently)
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sensitivity to heat/ice/tape
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Wound Healing Problems
- ☐ Other: _____

If you checked any of these, please explain: _____

_____

SURGICAL HISTORY

Have you had surgery before? ☐ Yes ☐ No If yes, when? _____

If yes, please check all that apply.

- ☐ Abdomen Surgery
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Brain Surgery
- ☐ Fracture Surgery
- ☐ Gastrectomy
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Joint Replacement
- ☐ Mastectomy
- ☐ Orthopedic Surgery
- ☐ Other: _____

ALLERGIES

Do you have any known allergies? ☐ Yes ☐ No

If yes, please describe: _____

PERSONAL INFORMATION

What activities are you unable to do now, as a result of your condition? _____

_____

PATIENT LABEL

What activities do you need to be able to resume when you finish therapy? _____

_____

Please check all that apply.

Living Status:
- ☐ Alone
- ☐ With Spouse
- ☐ With Adult Children
- ☐ With Young Children
- ☐ With Friend
- ☐ With Relative
- ☐ Other: _____

Responsible for Dependent Care:
- ☐ Young Children
- ☐ Disabled Children
- ☐ Elderly Parent
- ☐ Spouse
- ☐ None
- ☐ Other: _____

Physical Environment:
- ☐ Stairs
  # of Steps: _____
- ☐ Outside Home
- ☐ Inside Home
- ☐ Rails
  Both Sides
  One Side _____

Do you feel safe in your current relationship or home? ☐ Yes ☐ No

Occupation: _____

Do you smoke? ☐ Yes ☐ No If yes, what type? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ E-Cigarettes

Smokeless tobacco? ☐ Yes ☐ No If yes, what type? ☐ Snuff ☐ Chew

Alcohol use? ☐ Yes ☐ No Frequency: _____

LEARNING STYLE

What learning style is most effective for you? ☐ Listening ☐ Reading ☐ Observation ☐ Performance of Task

HISTORY OF FALLS

Have you fallen in the past year? ☐ Yes ☐ No

Do you feel unsteady when standing or walking? ☐ Yes ☐ No

Do you worry about falling? ☐ Yes ☐ No

MEDICATIONS

Are you currently taking any medication(s)? ☐ Yes ☐ No

If yes, please list medications and for what condition. Include over-the-counter and herbal medications. If you need more space, please attach a list to this form.

Medication	Condition / Why Used

Patient/Legal Representative Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

PATIENT LABEL