AGOURA HILLS PHYSICAL THERAPY
PATIENT HEALTH QUESTIONAIRE

Name:____ Date:_____/_____/_____

Date of Birth:__________________________

Please describe your current complaint or limitation: ____

____

Please describe how and when your problem began: ____

____ Specific Date if possible:_____/_____/_____

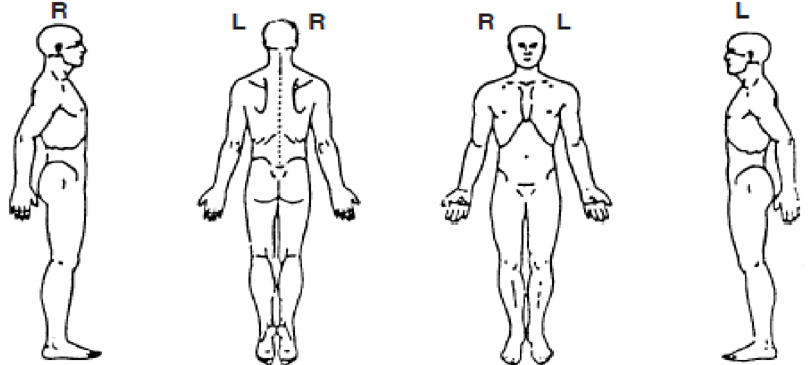
Did you have surgery for this condition?

❑ No ❑ Yes Date:_____/_____/_____

Please describe the nature of your pain:

❑ Sharp Pain	❑ Constant (76-100%)
❑ Dull (Pain) Ache	❑ Frequent (51-75%)
❑ Throbbing	❑ Occasional (26-50%)
❑ Numbness	❑ Intermittent (25% or less)
❑ Shooting	
❑ Burning	

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. ⇨ ⇨ ⇨



Indicate the intensity of your ***pain at rest:*** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your ***pain with movement:*** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: ❑ decreased ❑ not changed ❑ increased

Your symptoms are worse in: ❑ morning ❑ afternoon ❑ night ❑ increased during the day ❑ same all day

Have you had physical therapy treatment, for this condition, ***in the past***? ❑ No ❑ Yes

If yes, where were you seen:______________________________ Was treatment effective: ❑ No ❑ Yes

Occupation:________________________________ Has your work status changed because of this condition? ❑ No ❑ Yes

If you have ever had a listed condition in the past, please check in the PAST column. If you are presently having a listed condition, check in the PRESENT column. By providing this information, it allows your therapist to have a thorough understanding of your state of health.

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Heart Disease
☐	☐	Pacemaker
☐	☐	Osteoporosis
☐	☐	Diabetes
☐	☐	Seizures
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Headaches
☐	☐	Recent Weight Loss/Gain
☐	☐	Sensitivity to Heat/Cold
☐	☐	Metal Implants
☐	☐	Circulation Problems
☐	☐	Cancer Location:____________________Date:__________
☐	☐	Muscle Weakness
☐	☐	General Fatigue
☐	☐	Other

Hospitalization/Surgical Procedures:
(list if not described elsewhere)

____

____

____

____

Medications: ___________________________________

____

____

____

____

Referring Physician: ______________________________

How did you hear about us? ________________________

____

Patient's Signature *Date*