Patient Health Questionnaire

Omni Physical Therapy Services
333Earle Ovington Blvd, Uniondale NY 11553

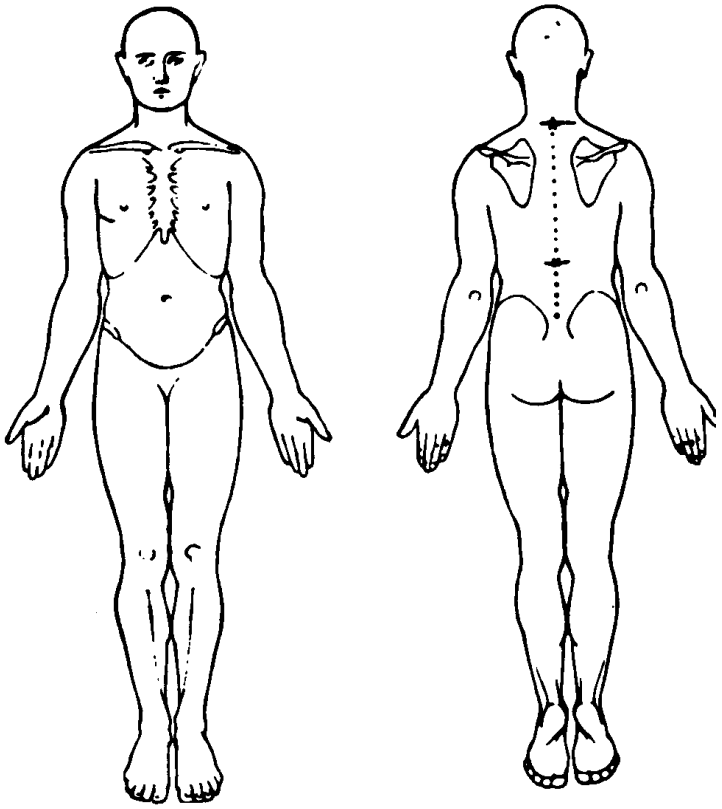
Patient Name **Today's Date**

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

Age **Height**_____ **Weight**_____ **Occupation**

What is your chief complaint? (Diagnosis, symptoms or condition)

Draw your area of symptoms



Do you now have:

___ dizziness / fainting / seizures
___ night pain
___ numbness / weakness
___ shortness of breath
___ fever / chills
___ bowel/bladder control problems
___ numbness in the genital area
___ are you pregnant
___ poor circulation / bruising
___ artificial joints
___unexplained muscle weakness

Have you ever had:

___ cancer (type: _____)
___ heart problems / pacemaker
___ high blood pressure
___ diabetes
___ rheumatoid arthritis
___ tuberculosis / hepatitis / HIV
___ osteoporosis
___ asthma
___ stroke
___chest pain
___fainting or dizziness

Does pain awaken you at night? ▢No ▢Yes Do you smoke?▢No ▢Yes Unexplained weight loss? ▢No ▢Yes
What test have you had for this problems? ▢x-ray ▢MRI ▢CT scan ▢other
Have you ever had surgery for this problem? ▢No ▢Yes List other surgeries
Are you feeling a high level of stress or anxiety? ▢No ▢Yes Have you had difficulty with depression ▢No ▢Yes
List the medication you take

How would you rate your PAIN? (0 to 10: 0 = no pain, 10 = unbearable pain)

Right now _____ At Best _____ At Worst _____

What activities are the most troublesome for you? (circle any that apply)

Sleeping, bed mobility, dressing, bather, other _____
Sitting, standing, walking, bending/lifting, housework, computer, reaching, other work_____
Sports – running, jumping, change of direction, other _____

Is there a physical reason not mention here why you should not follow an activity/ exercise program? If yes, please explain:

The information above is true and to the best of my knowledge.

Signature : _____ Date: _____