JERSEY CENTRAL PHYSICAL THERAPY
PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date: _____ Sex: _____

Occupation: _____ Leisure Activities: _____

Did you have surgery: Yes: ___ No: ___ Date: _____ Type of Surgery: _____

Describe your Current Complaint or Problem: _____

Describe how your problem began: _____

When did your problem begin: _____Specific Date if possible: _____

Your Symptoms are worse in: ____morning ____afternoon ____ night____increased during the day ____ same all day

Are your symptoms (check one):____Getting worse____ The same____Improving

I have difficulty with _____sleep _____dressing _____work _____driving _____walking _____standing

_____rising from a chair _____bending _____lifting ____Playing sports ____Running ____Calisthenics

In the past have you been treated for the same problem? ____Yes ____No, If yes, who did you see for this condition?:

_____When and what treatment did you receive?:_____

Please check off any of the following whose care you are under: Medical Doctor (MD): ____ Osteopath (DO): ____

Dentist: ____ Chiropractor: ____ Psychologist/Psychiatrist: ____ Physical Therapist: ____ Other: _____

Have you EVER or any immediate family member been diagnosed as having the following conditions:

	SELF		FAMILY			SELF	
High Blood Pressure	YES	NO	YES	NO	Angina/Chest Pain	YES	NO
Diabetes	YES	NO	YES	NO	Seizures/headaches	YES	NO
Cancer	YES	NO	YES	NO	Balance problems	YES	NO
Thyroid	YES	NO	YES	NO	Allergies/Asthma	YES	NO
Heart Disease	YES	NO	YES	NO	Emphysema/bronchitis	YES	NO
Rheumatoid Arthritis	YES	NO	YES	NO	Fibromyalgia	YES	NO
Other arthritic conditions	YES	NO	YES	NO	Chronic fatigue	YES	NO
Skin Problems	YES	NO	YES	NO	Anemia	YES	NO
Osteoporosis	YES	NO	YES	NO	Stroke	YES	NO
Kidney Disease	YES	NO	YES	NO	Incontinence	YES	NO
Multiple Sclerosis	YES	NO	YES	NO	Pregnancy	YES	NO

Other: _____

During the past 3 months have you had the following:

Any change in your health	YES	NO	Dizziness	YES	NO
Fever/chills/sweats	YES	NO	Numbness/tingling	YES	NO
Nausea/Vomiting	YES	NO	Difficulty swallowing	YES	NO
Change in appetite	YES	NO	Urinary Tract Infection	YES	NO
Unexplained weight change	YES	NO	Upper respiratory Infection	YES	NO
Changes in bladder/bowel	YES	NO	Stress	YES	NO
Shortness of breath	YES	NO	Depression	YES	NO

Other: _____

Date of last medical examination: _____Do you have recent Lab results? ____ Yes ____ No

Have you had any medical tests? ____ Yes ____ No, If Yes, please describe:_____

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ____Yes____No

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Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason:

	DATE	REASON		DATE	REASON
1	_____	_____	2.	_____	_____
3	_____	_____	4.	_____	_____
5	_____	_____	6.	_____	_____

Please describe any significant injuries for which you have been treated including fractures, dislocations, sprains and approximate date:

	DATE	INJURY		DATE	INJURY
1	_____	_____	2.	_____	_____
3	_____	_____	4.	_____	_____
5	_____	_____	6.	_____	_____

Please list any prescription medication yo are currently taking: (Pills, Injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Which of the following OVER-THE-COUNTER MEDICATIONS have you taken in the last week?

Aspirin	YES	NO	Decongestants	YES	NO
Tylenol	YES	NO	Laxatives	YES	NO
Aleve	YES	NO	Advil/Motrin/Ibuprophen	YES	NO
Antacid	YES	NO	Antihistamines	YES	NO
Vitamins/mineral supplements				YES	NO

How much caffeinated coffee or caffeine containing beverages do you drink per day?: _____ How many packs of cigarettes do you smoke per day?: _____ How many days per week do you drink alcohol?: _____ If one drink equals one beer or glass of wine, how much do you drink at an average sitting?: _____

My goals for physical therapy are (what do I expect from therapy): _____

_____

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

_____ _____

Patient Signature Date

OFFICE USE ONLY:

VITAL SIGNS:

_____ _____

Height Weight

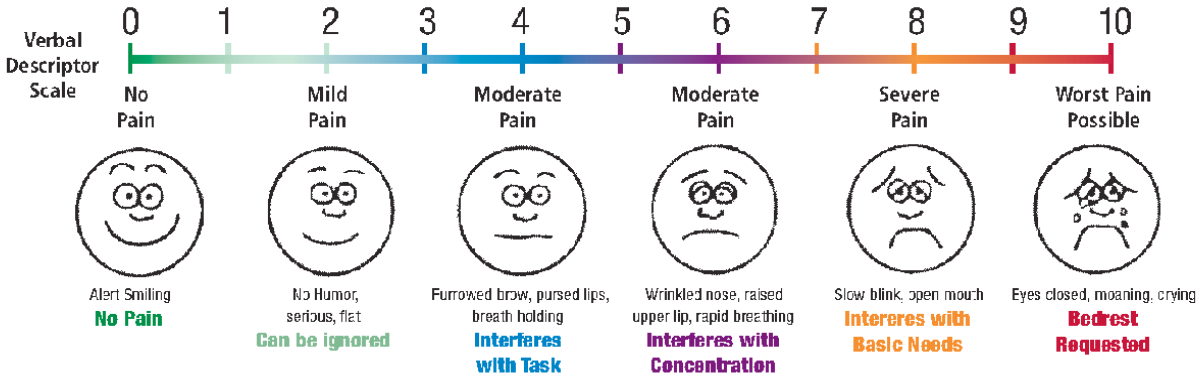
_____ _____ _____

Blood Pressure Heart Rate Temperature

Revised 12/2010

JERSEY CENTRAL PHYSICAL THERAPY

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0–10 scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.



WONG-BAKER FACIAL GRIMACE SCALE

ACTIVITY TOLERANCE SCALE	No Pain	Can be Ignored	Interferes with Task	Interferes with: Concentration	Interferes with Basic Needs	Bedrest Required
SPANISH	Nada de Dolor	Un Poquito de Dolor	Un Dolor Leve	Dolor Fuerte	Dolor Demasiado Fuerte	Un Dolor Insoportable
TAGALOG	Walang Sakit	Konting Sakit	Katamtamang Sakit	Matinding Sakit	Pinaka-Matinding Sakit	Pinaka-Malalang Sakit
CHINESE	不痛	輕微	中度	嚴重	非常嚴重	最嚴重
HINDI	Dard Nahi Hai	Bahut Kam	Hilne se Taklef Hoti Hai	Soch Nahin Sak Te	Kuch Nahin Kar Sakte	Dard Bahut Hai
PERSIAN (FARSI)	بدون درد	درد ملایم	درد معتدل	درد شدید	درد بسیار شدید	بدترین درد ممکن
VIETNAMESE	Không Dau	Dau Nhe	Dau Vira Phâi	Dau Nặng	Dau Thật Nặng	Dau Dôn Tận Cúng
JAPANESE	痛みがない	少し痛い	いくらか痛い	がなり痛い	ひどく痛い	ものすごく痛い

Prescribe the Nature of your pain:

1	Sharp Pain	5	Throbbing	9	Heavy
2	Shooting	6	Tingling	10	Tight
3	Burning	7	Numb	11	Pulling
4	Dull	8	Ache	12	Stabbing

Please describe the pattern or frequency of your pain:

A Constant (100%) day)

B Frequent (>once per day)

C Occasionally (once per day

D Infrequently (<once per week)

E Variable (changes)

F Intermitent