



TELESIS PHYSICAL THERAPY, INC.
Patient Health Questionnaire

Patient's Name: _____ Age: _____ Date: _____

Date of Injury/surgery: _____

1) Do you now have/or had any of the following:

	YES	NO		YES	NO
Diabetes			Sensitive to Heat/Ice		
High Blood Pressure			Pregnant (Currently)		
Heart Conditions			Allergies (Latex, Adhesives, Meds)		
Heart Attack			Previous Surgery		
Pacemaker			Hernia (Ventral, Inguinal, etc.)		
Headaches			Seizures		
Kidney Problems			Metal Implants		
Nervous Disorders			Cancer		
Asthma/Lung Conditions			Bladder/Bowel Control Problems		
Heart Burn			Ulcers		
Prostate Issues			Osteoporosis		
Use of Tobacco products, any type			Drink Alcohol		

If **YES** on any of the above, please explain and give approximate dates:

2) Are you presently taking medication? YES NO

If **YES**, please list what **medication, the dosage** and for **what condition. (complete or provide a list):**

3) Do you need assistance with any of the following:

Transportation	YES	NO	Meals	YES	NO
Shopping/Errands	YES	NO	Personal Care	YES	NO
Domestic Chores	YES	NO	Other _____		

4) Has your illness/disability caused any of the following:

Financial Problems	YES	NO	Family Problems	YES	NO
Emotional Problems	YES	NO	Other _____		
Depression	YES	NO			

5) Do you have any other problems or concerns we should be made aware of?

6) Have you fallen in the last year? YES NO If yes, how many times? _____

Name _____

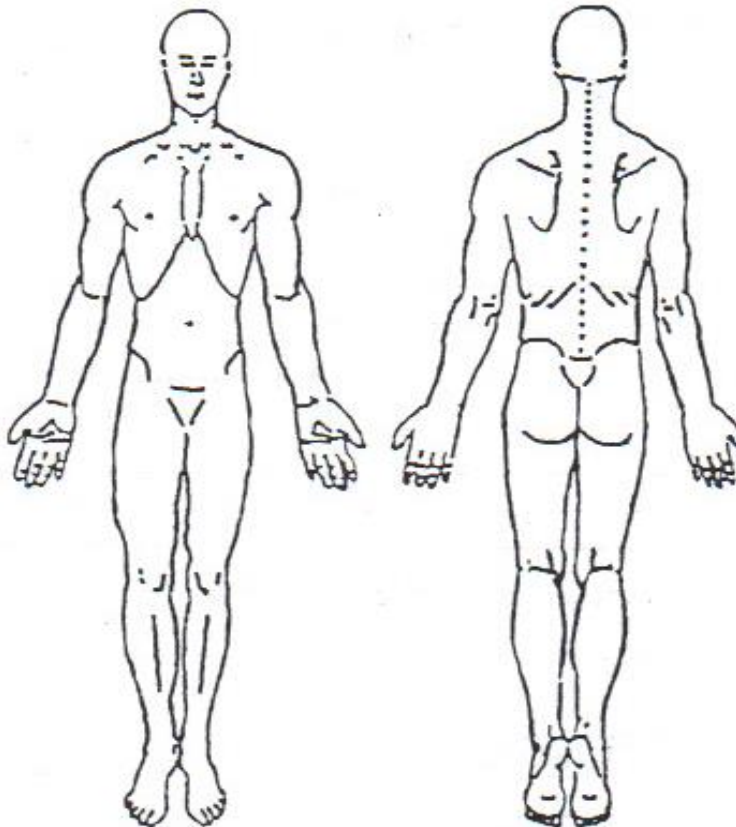
7) Have you had any Physical Therapy earlier in this year? YES NO

8) Do you need interpretive services for language or hearing impairments? YES NO

9) Reason for Physical Therapy? _____

10) Describe your symptoms and/or complaints: _____

11) Please shade in areas of concern on the diagrams:



12) In case of an emergency please notify: _____

Relation: _____

Phone Number(s): _____

