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		
Smoke Cigarattes			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? _________

Over

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? ____

____

____

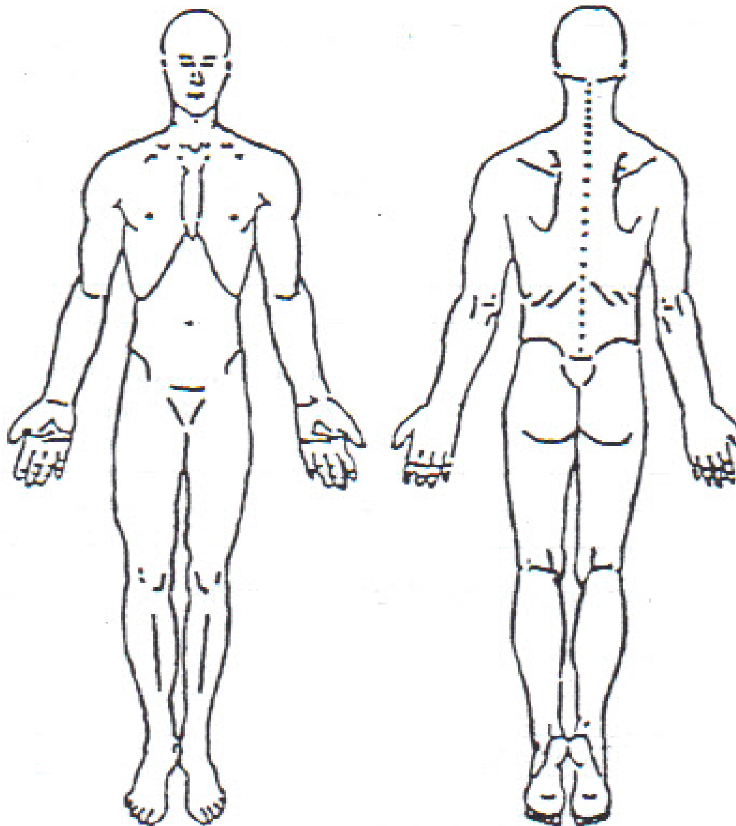
10) Describe your symtoms and/or complaints: ________________________________

____

____

____

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



12) In case of an emergency please notify:____

Relation: _________________________________ Phone Number(s): _____________________________