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 _____

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 _____Date _____

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? _____

_____

_____

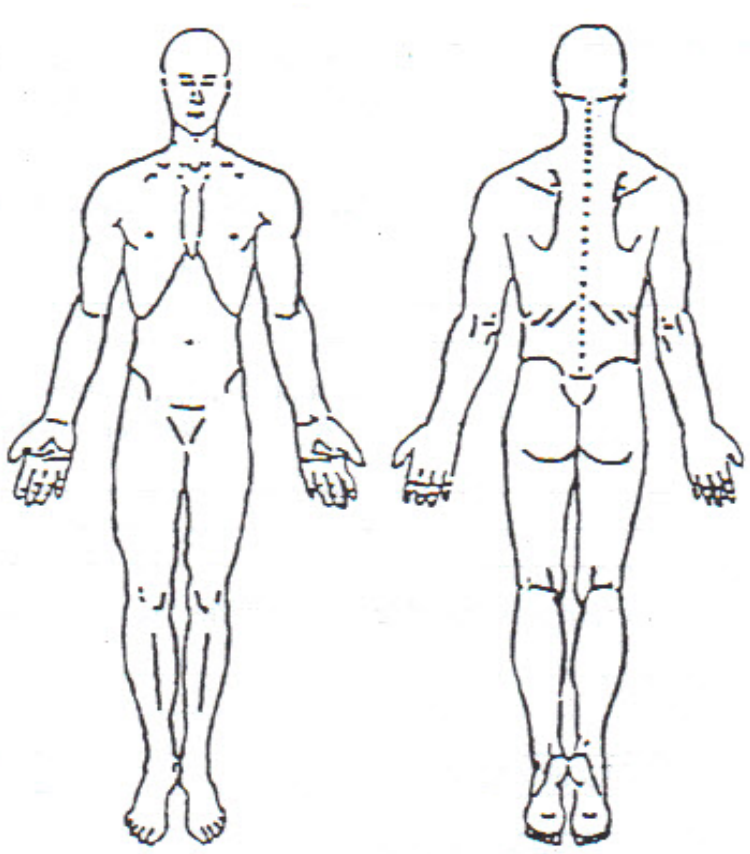
10) Describe your symtoms and/or complaints: _____

_____

_____

_____

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



12) In case of an emergency please notify:_____

Relation: _____ Phone Number(s): _____