



PHYSICAL THERAPY PROFESSIONALS, P.C.

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PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____

The following information that you provide concerning past and present conditions and diseases will assist your therapist in more thoroughly understanding your state of health. Please answer each question.

ARE YOU NOW EXPERIENCING OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

PLEASE CHECK THE APPROPRIATE RESPONSE.

PAST	PRESENT	NEVER	
			HIGH BLOOD PRESSURE
			ANGINA
			HEART ATTACK
			STROKE
			PACEMAKER
			ASTHMA
			HIV / AIDS
			CANCER (Location _____ Date _____)
			TUMOR
			SYSTEMIC LUPUS
			HEPATITIS
			EPILEPSY
			DIABETES
			RHEUMATOID ARTHRITIS
			ARTHRITIS
			OSTEOPOROSIS
			PREGNANCY
			TOBACCO USE (Packs/Day _____)
			DRUG OR ALCOHOL DEPENDENCY

Please rate your pain today on a scale of 0 to 10 (ie, 0-no pain to 10 being the worst) _____

Please list any allergies to medications or otherwise _____

Please list any and all Hospitalizations or Surgical Procedures not listed above. Please also include any Diagnostic testing or exams. _____

Please list any medications that you are CURRENTLY taking:

Patient's signature _____ Date _____