AIR Physical Therapy

Patient Health Questionnaire

*Please Print

Please ***circle*** any symptoms you ***CURRENTLY*** have.

General
Change in sleep
Fatigue
Night pain
Radiation treatment
Unexplained fever
Shakiness
Weight loss/gain
Tobacco
Tuberculosis
Cancer
Diabetes
Other_____

Cardiovascular
High blood pressure
Chest pain/pressure
Ankle swelling
Blood clots/phlebitis
Cholesterol problem
Lightheaded spells
Irregular heartbeat
Heart Murmur
Heart disease/heart attack
Mitral valve prolapse

Musculoskeletal
Osteoarthritis
Foot pain
Back pain
Muscle weakness
Joint pain/stiffness
Leg pain
Other_____

Mental Health
Memory loss
Anxiety
Chronic fatigue
Depressed mood
Difficulty concentrating

Neurological
Dizziness
Loss of sensation
Paralysis
Seizures
Stroke/CVA
Tremor
Headaches/severe
Numbness/tingling

Respiratory
Asthma
Emphysema
Shortness of breath
Wheezing

Medications: If you are on numerous medications, you may bring a list for us to copy and attach to form.

None _____

Name_____ Reason taking _____ Dosage_____ Frequency_____
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Allergies: NO___ List allergies: _____ _____ _____

Past Surgical History: **Check surgeries you have already had & when if known**

Heart____ What was done _____ Reason _____ Yr._____
Lung____ What was done _____ Reason _____ Yr._____
Total joint replacement: Which joint_____Reason _____ Yr._____
(If more than one joint): Which joint_____Reason_____ Yr._____
Which Joint_____ Reason_____ Yr._____
Fracture Repair: Of _____ Reason_____ Yr._____
Back Surgery: What was done_____
Reason_____ Yr._____
Abdominal surgery: What was done_____
Reason_____ Yr._____
Other: Specify _____ Reason_____ Yr._____

Tests you have had: X-rays _____ MRI _____
CT Scan _____ Circulation _____ Emg/NCV _____

NAME:_____ DATE:_____ **<u>PLEASE COMPLETE OTHER SIDE</u> **