KEN-TON PHYSICAL THERAPY
2438 ELMWOOD AVE, KENMORE NY 14217
PHONE (716) 873-9154 FAX (716) 875-3796

PATIENT HEALTH QUESTIONNAIRE

NAME:_____AGE_____ PRESENT WEIGHT_____ HEIGHT_____ RIGHT/LEFT HANDED

PLEASE DESCRIBE YOUR CURRENT COMPLAINT OR LIMITATION_____

_____

HOW DID YOUR PROBLEM BEGIN?_____

_____

WHEN DID YOUR CONDITION START?_____ _____DATE:_____/_____/_____

HAVE YOU HAD THIS PROBLEM BEFORE ☐ YES ☐ NO DID YOU HAVE SURGERY(for this problem) ☐ YES ☐ NO DATE:_____/_____/_____

PLEASE INDICATE YOUR PRESENT PAIN

0 1 2 3 4 5 6 7 8 9 10

PLEASE INDICATE YOUR PAIN AT ITS BEST (PAST 2 WEEKS)

0 1 2 3 4 5 6 7 8 9 10

PLEASE INDICATE YOUR PAIN AT ITS WORST (PAST 2 WEEKS)

0 1 2 3 4 5 6 7 8 9 10

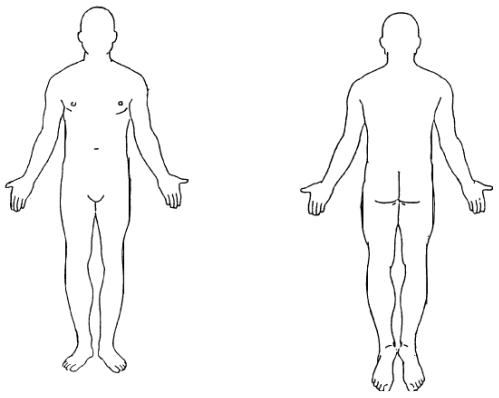
HOW FREQUENT IS YOUR PAIN? ☐ CONSTANT ☐ 75% OF THE TIME

☐ 50% OF THE TIME ☐25% OF THE TIME

SINCE THIS CONDITION BEGAN, HAVE YOUR SYMPTOMS

☐DECREASED ☐ INCREASED ☐ NOT CHANGED

MARK YOUR SYMPTOMS ON THE PICTURE BELOW



NUMBNESS
"""""""""
PINS AND NEEDLES
OOOOOOOO
BURNING
XXXXXX
STABBING
///////
ACHE
^^^^^^

WHAT TIME OF THE DAY ARE YOUR SYMPTOMS THE WORST?_____

PLEASE CIRCLE ALL THAT APPLY

HIGH BLOOD PRESSURE	SYSTEMIC LUPUS	THYROID (HYPER/HYPO)	CHEST PAIN	TUMOR
HIGH CHOLESTEROL	HEART ATTACK	HEPATITIS	OSTEOPOROSIS/OSTEOPENIA	STROKE
EPILEPSY/ SEIZURES	ANEURYSMS	ASTHMA	DIABETES	LATEX ALLERGY
HIV/AIDS	RHEUMATOID ARTHRITIS	MIGRAINES	TUBERCULOSIS	BOWEL/ BLADDER CHANGES
DRUG OR ALCOHOL	CANCER DATE:_____	OSTEOARTHRITIS - LOCATION:	OTHER:_____	_____
DEPENDENCE	LOCATION:_____	_____	_____	_____

ARE YOU PREGNANT? ☐ YES ☐ NO DO YOU SMOKE? ☐ YES packs/day_____ ☐ NO

LIST ALLERGIES_____

LIST MEDICATIONS(include dosage)_____

_____

PLEASE LIST HOSPITALIZATIONS AND SURGICAL PROCEDURES(include dates) _____

_____

PLEASE CIRCLE WHICH DIAGNOSTIC TESTS YOU HAVE HAD FOR THIS CONDITION

X-RAY	MRI	CAT SCAN	EMG/NERVE CONDUCTION
BONE SCAN	BLOOD TESTS	ULTRA SOUND/ DOPPLER	

PLEASE CIRCLE WHAT TREATMENTS YOU HAVE RECEIVED FOR THIS CONDITION

REST	EXERCISE	PHYSICAL THERAPY	CHIROPRACTIC	MASSAGE THERAPY
ACUPUNCTURE	MEDICATIONS	HEAT OR ICE	OTHER _____	_____

OCCUPATION:_____ HOURS PER WEEK:_____ FULL DUTY /LIGHT DUTY/ OFF WORK - SINCE____/____/____

WORK DUTIES:_____

_____

PATIENT SIGNATURE_____ DATE:_____/_____/_____