ROCKY MOUNTAIN PHYSICAL THERAPY

Patient Health Questionnaire

Name: _____ **Date**: _____

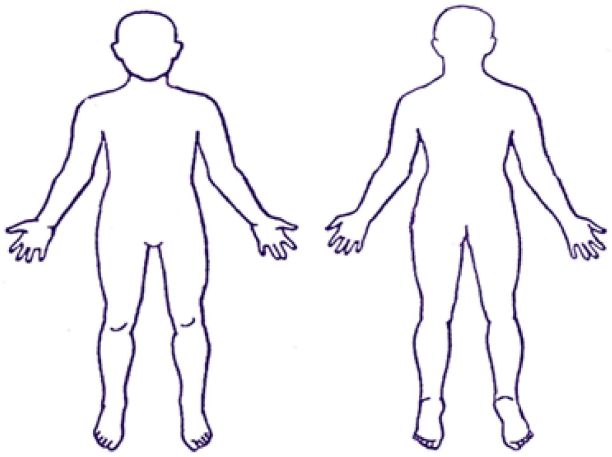
Describe your symptoms: _____

_____

When did your symptoms start? _____

How did your symptoms start? _____

Indicate below where you have pain or symptoms:



How often do you experience your symptoms?

__ Constantly (75-100% of the day)
__ Frequently (50-75% of the day)
__ Occasionally (25-50% of the day)
__ Intermittently (0-25% of the day)

What describes your symptoms?

__ Sharp __ Shooting __ Dull ache
__ Burning __ Throbbing __ Numb/tingling

How are your symptoms changing? (circle)

Getting better Getting worse Not changing

During the last month:

1. Circle the average intensity of symptoms: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)
2. How much has pain interfered with your normal work (including housework and occupation)?
   a. __ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely
3. How much of the time has your condition interfered with your social activities?
   a. __ Not at all __ A little bit __ Some of the time __ Most of the time__ All the time

In general, how would you describe your current overall health?

__ Excellent __ Very good __ Good __ Fair __ Poor

What have you tried to improve your symptoms?

__ Physical therapy __ Chiropractic __ Medical doctor __ Injections __ Cold/hot packs
__ CBD/alternative __ Medication __ Other: _____

What tests have you had for your symptoms and when were they performed?

X-rays: _____ MRI: _____ CT scan: _____ Other: _____

What is your occupation? _____

Patient/Guardian Signature: _____ **Date:** _____