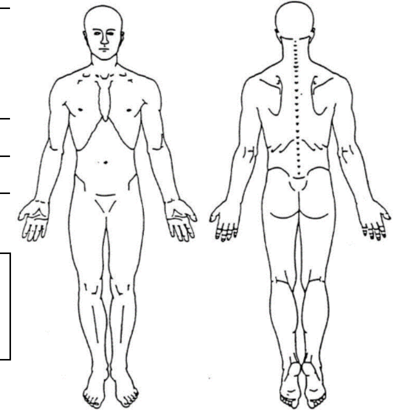
Medical History

Patient Name (*please print*) ______________________ Date ______________

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Mark an **X** on the picture where you have pain or other symptoms



Can you perform your daily activities? YES / NO (Describe)

Have you ever had physical therapy for this condition? YES / NO Year:

Current compliant (how do you feel today):

0 1 2 3 4 5 6 7 8 9 10

(0 = No Pain) (Unbearable Pain = 10)

PHQ-9:

IN THE LAST TWO WEEKS, HOW OFTEN HAVE YOU EXPERIENCED THE FOLLOWING?				
Please select a number for each:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

HAVE YOU RECENTLY NOTICED ANY OF THE FOLLOWING?					
Y / N	Weight Loss/Gain	**Y / N**	Weakness	**Y / N**	Dizziness
Y / N	Nausea/Vomiting	**Y / N**	Fever/Chills/Sweats	**Y / N**	Bladder/Bowel Changes
Y / N	Fatigue	**Y / N**	Numbness or Tingling	**Y / N**	Chest Pain
HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?					
Y / N	Heart Problems	**Y / N**	Hearing loss/Disorder	**Y / N**	Cancer
Y / N	High Blood Pressure	**Y / N**	Eye Disease	**Y / N**	Osteoporosis
Y / N	Circulation Problems	**Y / N**	Muscular Disease/Disorder	**Y / N**	Depression
Y / N	Rheumatoid Arthritis	**Y / N**	Multiple Sclerosis	**Y / N**	Past Pregnancy
Y / N	Other Arthritic Condition	**Y / N**	Tuberculosis	**Y / N**	Current Pregnancy
Y / N	Stroke	**Y / N**	Epilepsy/Seizures	**Y / N**	Chemical Dependency
Y / N	Lung Disease	**Y / N**	Hepatitis	**Y / N**	Ulcers
Y / N	Asthma	**Y / N**	Kidney Disease	**Y / N**	Diabetes Type: 1 / 2
Y / N	Pacemaker	**Y / N**	Thyroid Problems	**Y / N**	Implanted Devices

LIST ANY SURGERIES, MEDICAL CONDITIONS, OR INJURIES FOR WHICH YOU HAVE BEEN TREATED:

LIST ALL PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS, VITAMINS, & HERBAL SUPPLEMENTS YOU ARE CURRENTLY TAKING:

Medication Name	Dosage	Frequency	Route: Oral, Injection, Etc.

Signature ______________________ Date ______________

PHQ-9

(Cont. from front of page)

IN THE LAST TWO WEEKS, HOW OFTEN HAVE YOU EXPERIENCED THE FOLLOWING?				
Please select a number for each:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add columns: *(including answers from previous page)*		+	+	=
Total: *(Healthcare professional: for interpretation of total, please refer to accompanying scoring card)*				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult