CHRIS PRENTISS PHYSICAL THERAPY
763 Larkfield Rd, Suite 101
Commack, NY 11725
P 631 – 462 – 0118
F 631 – 462 – 0827
chrisprentisspt@gmail.com

PATIENT HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Height: _____ Weight: _____ Marital Status: _____ # of Children: _____

Occupation: _____ Presently Working: YES / NO / Retired

Referred to us by: ☐ Doctor _____ ☐ Relative / Friend ☐ Insurance ☐ Other: _____

Have you ever had Physical Therapy for this condition? YES / NO If yes, when? _____

Where is Your Pain Now?

Please mark the areas on the body diagram where you feel the described sensation. Please use the appropriate symbols.

Mark the areas of referred pain. Include all affected areas.

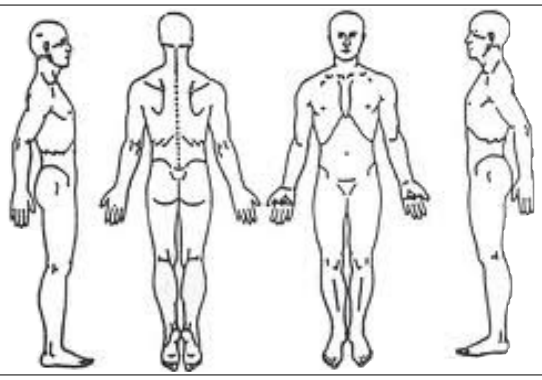
Ache ^^^^^

Numbness ○ ○ ○ ○

Burning xxxxx

Stabbing //////

Pins and Needles ====



Do You Engage In Any of The Following?

	YES	NO		
Exercise / Sports:	☐	☐	Type / Frequency	_____
Smoking:	☐	☐	Estimated Use	_____
Alcohol:	☐	☐	Estimated Use	_____
Coffee / Caffeine:	☐	☐	Estimated Use	_____

Medical History

If you check **Current** or **Past**, **Please Comment**

	Current	Past	None	Comments
Cardiovascular	☐	☐	☐	_____
Pulmonary	☐	☐	☐	_____
Gastrointestinal	☐	☐	☐	_____
Dermatologic	☐	☐	☐	_____
Genitourinary	☐	☐	☐	_____
Ear, Nose $ Throat	☐	☐	☐	_____
Hematological	☐	☐	☐	_____
Immunological / Infectious Disease	☐	☐	☐	_____
Musculoskeletal	☐	☐	☐	_____
Cancers / Tumors	☐	☐	☐	_____
Neuropsychiatric	☐	☐	☐	_____
Other	☐	☐	☐	_____

Please list any surgeries you have undergone with the dates: _____

_____

Please list all medications you are taking at this time: _____

_____

Please list any allergies you have: _____

Emergency Contact: _____ Phone # _____