AccelAbility® BALANCE & THERAPY

Patient Health Questionnaire

Name:_____Date:_____DOB:_____

Do you have a pacemaker? [ ] Yes [ ] No Internal stimulator (brain/spinal)? [ ] Yes [ ] No Are you pregnant? [ ] Yes [ ] No

Chief Complaint: _____When did present symptoms start? _____

Cause: _____

What medical help have you sought for current problem: [ ] Doctor [ ] Chiropractor [ ] Physical Therapy [ ] Occupational Therapy

Are you currently receiving Home Health Services? [ ] Yes [ ] No If yes, explain: _____

Have you had any x-rays to diagnose current problem? [ ] Yes [ ] No If yes, when & results? _____

Have you had other tests performed regarding above problem? [ ] Yes [ ] No If yes, what test, when & results? _____

_____

Have you had any loss of sensation with current problem? _____

Can you get comfortable at night? _____

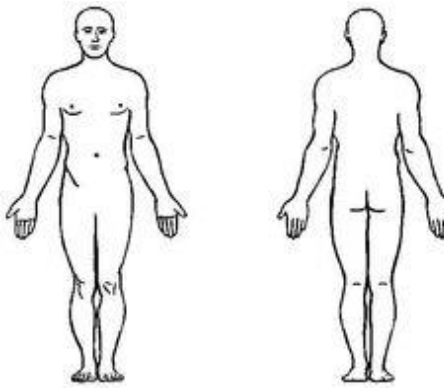
Have you had similar problem before? [ ] Yes [ ] No If yes, how long ago?_____

Have you ever had physical or occupational therapy for this similar problem? [ ] Yes [ ] No If yes, what type of treatment did you received? _____

Where is the pain/symptom? (mark diagram to the right)

Has the pain spread? [ ] Yes [ ] No If yes, where? _____

_____



Describe your pain/symptoms: (check all that apply)

[ ] vertigo	[ ] stays all the time	[ ] head injury/concussion
[ ] lightheadedness	[ ] comes and goes	[ ] migraine/headache
[ ] imbalance	[ ] throbbing	[ ] shooting
[ ] ear pressure/pain	[ ] dull/ache	[ ] numbness
[ ] feeling off	[ ] sharp	
[ ] motion intolerant	[ ] burning	

[ ]Constant (76-100%) [ ] Frequent (51-75%) [ ] Occasional (26-50%) [ ] Intermittent (25% or less)

Symptoms at rest from 0 (none) to10 (unbearable): _____

Symptoms with activity 0 (none) to 10 (unbearable):_____

Symptoms since condition began: [ ] decreased [ ] not changed [ ] increased

Symptoms worse:[ ] morning [ ] afternoon [ ] night [ ] increased during day

[ ] same all day

What activities/positions increase your symptoms? _____

_____

What activities/positions decrease your symptoms? _____

_____

What activities does pain interfere with or prevent you from doing? ____

_____

Please rate your pain/comfort level from 0-10: (if applicable)_____

What is your goal for pain relief using above scale? _____

Weight: _____ Height:_____

Have you fallen in the last year? [ ] Yes [ ] No

Medications: (Name/Dosage/Frequency) **or provide list**

_____

_____

_____

_____

_____

Hospitalization/Surgeries:

_____

_____

_____

_____

Have you or do you have any of the following:

[ ] Cancer [ ] Diabetes [ ] Epilepsy [ ] Heart Disease

[ ]Respiratory Problems [ ] High Blood Pressure

[ ] Metal Implants [ ] Arthritis [ ] Stroke [ ] Other _____