PQRS Health Questionnaire – PT Only

Patient Name:_____ Date:_____

Section 1, Medications:

Please list your current medications, including: ***over the counter medications, vitamins/mineral/dietary supplements, prescription medications and any herbal supplements:***

For each medication, please list the following:

	Name of Medication/ Vitamin/Herbal Supplement	Dosage	Frequency	Route of Administration*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

*(Definition of route of administration: oral, subcutaneous, IV, etc.)

If more space is needed, continue on an attached page.

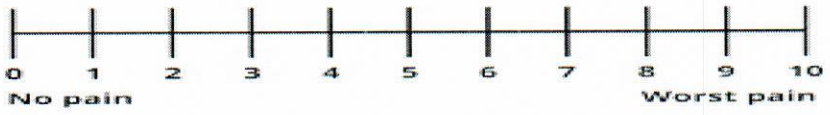
Section 2, Pain:

Do you have pain: Yes_____ No_____

If yes, please list where:_____

Using the pain scale below, please rate the amount of pain you have right now:_____

Using the pain scale below, please rate your pain when it is at it's worst:_____



Rate your pain or pain relief from 0-10

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)

Section 3, Falls:

Have you had 2 or more falls in the past 12 months? Yes_____ No_____

If yes, how many falls have you experienced in the past 12 months?_____

Have you had a fall that resulted in an injury in the past 12 months? Yes____ No_____

If yes, what kind of fall did you suffer and what was the subsequent injury?_____

_____

Health History:

Are you currently receiving services from Home Health providers (either nursing or therapy)? ___ Yes ___ No

Have you had a complete medical check-up in the last year? ___Yes ___No

Do you now have or have you recently had any of the following complaints:

- ☐ Pain or a feeling of heaviness in your chest
- ☐ Pulsating pain anywhere in your body
- ☐ Constant and severe pain in lower leg (calf)
- ☐ Frequent or severe abdominal pain
- ☐ Persistent pain at night
- ☐ Unexplained weight loss (10-15 lbs in 2 weeks)
- ☐ Unusual lumps or growths

Do you currently have or have you ever had any of the following medical conditions?

___ Asthma	___ Bronchitis	___ Diabetes	___ Hernia
___ Heart Disease	___ Chest Pain	___ Epilepsy	___ Tuberculosis
___ Epilepsy	___ Arthritis	___ High Blood Pressure	
___ Cancer	___ HIV/AIDS	___ Low Blood Pressure	
___ Sickle Cell Anemia		___ Other:_____	

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)