CITY SPORTS MEDICINE

Patient Health Questionnaire

Reason for Visit

What brings you into the office today?

What event or incident is this related to?

☐Work Accident ☐Car Accident ☐Sports

☐Routine Activity ☐Exercise ☐Other:

When did the problem begin?

Have you or are you planning to apply for disability?

☐Yes ☐No

Please describe any previous treatment or care you received:

Is there a lawsuit or litigation pending regarding pain?

☐Yes ☐No

Pain Assessment

If you have pain, where is the location of your pain?

Are your symptoms improving, worsening, or not changing?

☐Better Gradually ☐Better Rapidly ☐Worse Gradually

☐Worse Rapidly ☐No change

Indicate your level of pain on a scale of 1 – 10

☐1 ☐2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10

What makes your symptoms better?

☐Rest ☐Ice ☐Heat

☐Stretching ☐Advil/Aleve ☐Other:

How do you describe your pain?

☐Sharp ☐Dull ☐Aching

☐Throbbing ☐Burning ☐Other:

What makes your symptoms worse?:

☐Activity ☐Sitting ☐Standing

☐Lying Down ☐Walking ☐Running

☐Bending ☐Climbing Stairs ☐Descending Stairs

☐Exercising ☐Other:

What is the frequency of symptoms?

☐Constant ☐Comes and Goes

Medical History

Please list any medical conditions:

Family Medical History

Please list any significant family medical conditions:

Hospitalizations & Surgeries

Please list any previous hospitalizations and surgeries:

Medications

Please list any medications you are currently taking:

Allergies

Are you allergic to any of the following?

☐Aspirin	☐Latex	☐Sulfa
☐Codeine	☐Anesthesia	☐Adhesive Tape
☐Antibiotics	☐Iodine Contrast	

Please list other allergies?

Miscellaneous

Do you currently have any of the following symptoms?

☐Headaches	☐Dizziness	☐Vision Changes
☐Joint Pain	☐Fever	☐Difficulty Breathing
☐Cough	☐Chest Pain	☐Abdominal Pain
☐Constipation	☐Diarrhea	☐Dark/Bloody Stools
☐Weight Loss	☐Incontinence	☐Urinary Retention

Lifestyle Factors

Have you ever smoked?	☐Yes	☐No	# years:
Do you smoke now?	☐Yes	☐No	# packs/day:
Do you drink alcohol?	☐Yes	☐No	# drinks/week:
Do you exercise regularly?	☐Yes	☐No	# times/week:
Do you use recreational drugs?	☐Yes	☐No	Types:

Woman's Health Only

Do you have any menstrual irregularities?	☐Yes	☐No
Have you reached menopause?	☐Yes	☐No
Are you pregnant?	☐Yes	☐No
Are you breastfeeding?	☐Yes	☐No

Patient's Name (Print) _____

Patient's Signature _____ Date _____