Back in the Game
SPORTS MEDICINE, LLC

Patient Health Questionnaire for new patients

Patient Name: _____ **Date** _____

Present Complaint: (Describe your symptoms) _____

When did your problem begin: (specific date) _____

What caused your symptoms? _____

1) How often do you experience symptoms? ☐ Constant (100-76%) ☐ Frequent (75-51%) ☐ Occasional (50-26%) ☐ Intermittent ((>26%)

2) Describe the nature of your symptoms:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

3) Since your problem began, is the pain: ◯ Getting Better ◯ Not Changing ◯ Getting Worse

4) indicate the average intensity of your symptoms:

◯ 0 (no pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (worst pain)

13) Have you had similar symptoms in the past? ◯ Yes ◯ NO

14) If you have received treatment in the past for the same or similar symptoms, who did you see?

◯ This Office ◯ Other Chiropractor ◯ MD ◯ PT ◯ Other

Other Medical History

☐ Allergies ☐ Depression ☐ Osteoporosis ☐ Prostate problems

☐ Arthritis ☐ Diabetes ☐ Skin condition ☐ Gynecology problems

☐ Asthma ☐ Hepatitis ☐ Stroke ☐ Thyroid problems

☐ Cancer ☐ Hypertension ☐ Scoliosis

In the last 30 days:

☐ Unexplained weight loss

☐ Unusual headaches

☐ Infection or Fever

Surgeries

☐ Cardiovascular ☐ Abdominal / other organ ☐ Upper / lower extremities ☐ Spine / neurological

Parent Family History

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ High blood pressure / Heart ☐ Back problems

Prescription medication

☐ Asthma / Allergy ☐ Anti-coagulant ☐ Anti-depressant ☐ Anti-inflammatory ☐ Antibiotic

☐ Cortico-steroids ☐ Thyroid ☐ Pain reliever ☐ Birth control ☐ Other

Previous fractures or serious hospitalizations: _____

Please give your height, weight, other significant stressors): _____

Signature _____

Print Form