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Patient Questionnaire

Please complete the following questions as COMPLETELY and ACCURATELY as possible to better allow the doctor to provide quality care.

NAME: DATE OF BIRTH: AGE:

EVALUATION DATE: SSN: EMAIL:

ADDRESS: HOME TELEPHONE:

CITY/STATE/ZIP: ALTERNATE PHONE:

Left Handed Right Handed

DATE OF INJURY:

PRIMARY COMPLAINT (Provide symptoms):

BRIEF DESCRIPTION OF ACCIDENT/INJURY, IF APPLICABLE:

DO SYMPTOMS INCLUDE (check all that apply and list locations): NUMBNESS TINGLING WEAKNESS NONE

HAS PAIN AFFECTED (check all that apply): SLEEP APPETITE BLADDER BOWEL NONE

WHICH TESTS, IF ANY, HAVE BEEN COMPLETED IN THE PAST TO EVALUATE YOUR PROBLEM?

X-RAY MRI CT SCAN BONE SCAN EMG (nerve testing) MYELOGRAM LAB TESTS

OTHER:

PREVIOUS TREATMENTS (check all that apply):

MEDICATIONS THERAPY NERVE BLOCKS INJECTIONS SURGERY CHIROPRACTOR

TENS/E-STIM COUNSELING OTHER:

PREVIOUS PHYSICIANS:

HAVE YOU EVER HAD A PROBLEM WITH THE SAME BODY AREA/PART(S) FOR WHICH YOU ARE BEING SEEN TODAY? Y N

MEDICAL HISTORY: Mark any of the following with C if you currently have OR P if you have had in the past. Please check NONE if not applicable.

CONSTITUTIONAL NONE
Recent weight change (Gain or Loss) Fever Night sweats Fatigue

CARDIOVASCULAR NONE
Heart disease Chest pain Palpitations/Irregular heartbeat Hand or foot swelling Murmur
High blood pressure Rheumatic fever Heart attack Congestive heart failure

RESPIRATORY NONE
Chronic/frequent cough Coughing blood Shortness of breath Asthma/wheezing Bronchitis
Emphysema COPD Recent cold or flu

GENITOURINARY NONE
Kidney stones Frequent urination Blood in urine Burning/painful urination Incontinence Sexual difficulty

GASTROINTESTINAL NONE
Hiatal hernia Ulcers Bleeding Jaundice/Liver problems Abdominal pain Hepatitis A, B, or C
Loss of appetite Diarrhea Change in bowel movements Nausea/vomiting Irritable bowel

PSYCHIATRIC ___ NONE

___ Depression ___ Anxiety disorder ___ Nervousness ___ Personality change ___ Insomnia ___ Other

MUSCULOSKELETAL ___ NONE

___ Arthritis ___ Joint pain ___ Joint stiffness/swelling ___ Back pain ___ Neck pain ___ Difficulty walking ___ Muscle pain/cramps

INTEGUMENTARY (skin or breast) ___ NONE

___ Rash or itching ___ Change in skin color ___ Change in nails/hair ___ Varicose veins ___ Breast discharge/pain/lump

NEUROLOGICAL ___ NONE

___ Stroke ___ Head injury ___ Balance problems ___ Falls ___ Tremor ___ Multiple sclerosis ___ Lightheadedness
___ Dizziness ___ Vision change ___ Guillain Barre ___ Seizures ___ Numbness/Tingling ___ Weakness
___ Memory change ___ Polio ___ Parkinson's ___ Headaches (frequent or recurrent)

ENDOCRINE ___ NONE

___ Diabetes ___ Thyroid disease ___ Osteoporosis ___ Increased thirst or urination ___ Temperature intolerance ___ Hormone probs.

HEMATOLOGIC/IMMUNOLOGIC ___ NONE

___ Sickle Cell Anemia/Trait ___ Anemia ___ Bleeding/clotting problems ___ Bruising tendency
___ Tuberculosis ___ AIDS/HIV positive ___ Blood transfusions ___ Cancer and location _____

FEMALE PATIENTS: Is there any possibility you may be pregnant? No Yes. If yes, how far along: _____

ALLERGIES AND INTOLERANCES: NONE Penicillin Sulfa Tetanus Other antibiotics: _____
 Novacaine/anesthetics Aspirin or pain remedies Steroids Iodine/antiseptics Narcotics _____
 Other _____

OTHER MEDICAL CONDITIONS OR SURGERIES (Please list type and approximate dates): _____

MEDICATIONS (List names and doses of ALL CURRENT medications. Use back of form if needed.): _____

ANY FAMILY MEMBER WITH A SERIOUS ILLNESS (Check all that apply)? ___ NONE Diabetes Heart/Blood pressure/Stroke Lung disease
 Cancer Neurologic disorder Arthritis Other _____

SOCIAL HISTORY:

Smoking: Never Quit ___ years ago Rarely Daily and amount per day _____
Alcohol: Never Rare Moderate Social Daily and amount per day _____
Other Drugs: Never In the past but quit ___ years ago Continued use
Marital status: Single Married Separated Divorced Widowed
Residence: House Apartment Mobile Home Town House Other _____
Stairs? None Yes, ___ to enter and ___ once inside (approximately)
Do you drive? Yes No Exercise? No Yes _____

LAST COMPLETED GRADE IN SCHOOL: <8 8 9 10 11 12 13 14 15 16 >16

WORK HISTORY: Occupation: _____ Retired Not currently working Light/Modified Duty due to injury

EMPLOYER	TYPE OF EMPLOYMENT	HOW LONG?

Please use the back of this form to provide any other important information. There is additional information on the back of this page.