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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

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.**