Date: _____

Patient Questionnaire

NAME: _____DOB: _____

PCP: _____ REFERRING PROVIDER: _____

MEDICAL HISTORY: *Please circle the following that apply.*

- Diabetes
- Heart Disease
- High Blood Pressure
- Asthma
- Blood clots or clotting disorder
- Osteoporosis
- Cancer (type): _____
- Other:_____
  _____
  _____
  _____
  _____
  _____

SURGICAL HISTORY Please list any operations you have had (Type, Year & Surgeon):

_____
_____
_____
_____
_____
_____

FAMILY HISTORY: *Please list family members.*

- Diabetes_____
- Heart Disease_____
- Hypertension_____
- Stroke_____
- Cancer (type):_____
- Other:_____
  _____
  _____
  _____

Most recent occupation held: _____
Currently Working? Yes or No
If you're not currently working, reason? Retired Disabled Other: _____
Last Date Worked: _____

SOCIAL HISTORY: *Please circle that apply*
Lives with: Alone Spouse Significant Other Friend Children (#): _____

NICOTINE USE: Current Quit/When_____ Never
CIGARETTES: Packs Per Day _____ Years_____ **SMOKELESS TOBACCO:** Amount_____ Years_____
VAPOR _____ **GUM** _____ **LOZENGES** _____ **INHALER** _____
ALCOHOL: Yes No Former Drinks Per Day_____
DRUG USE: Yes No Former Substance_____

DRUG ALLERGIES: Yes or No Please List: _____
OTHER ALLERGIES: Yes or No Please List: _____
LATEX ALLERGY: Yes or No

Name & DOB: _____ Date: _____

CURRENT MEDICATIONS (attach separate list if more space is needed)

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING	PRESCRIBING PHYSICIAN

CONSTITUTIONAL
- Fatigue
- Fever
- Chills
- Night Sweats
- Weight Gain
- Weight Loss
- Loss of Appetite

EYES
- Double Vision
- Vision Changes
- Cataracts
- Blurred Vision
- Glaucoma

HEENT
- Thyroid Lump
- Difficulty Swallowing
- Hearing Loss
- Ear Pain
- Ringing in Ears
- Sinus Pain

CARDIOVASCULAR
- Leg Pain with Walking
- Swollen Hands
- Swollen Feet
- High Cholesterol
- Chest Pain
- Irregular Heart Beat
- Leg Swelling
- High Blood Pressure
- Irregular Pulse
- Heart Murmur

ALLERGY/IMMUNOLOGY
- Environmental Allergy
- Food Allergy
- Latex
- Drug Allergies

RESPIRATORY
- Shortness of Breath
- Chronic Cough
- Spitting up Blood
- Wheezing
- Bronchitis
- Pneumonia

GASTROINTESTINAL
- Constipation
- Ulcers and Gastritis
- Nausea
- Diarrhea
- Abdominal Pain
- Reflux/Indigestion
- Incontinence of Stool

SKIN
- Rash
- Dryness
- Skin Lesions
- Eczema

GENITOURINARY
- Urgency of Urination
- Pain with Urination
- Night Time Urination
- Urinary Tract Infection
- Kidney Stones
- Blood in Urine
- Frequency of Urination
- Incontinence of Urination
- Sexual Dysfunction

NEUROLOGICAL
- Numbness/Tingling
- Seizures
- Muscular Weakness
- Memory Difficulty
- Speech Difficulty
- Difficulty Concentration
- Headaches/Migraines

MUCULOSKELETAL
- Joint Pain
- Back Pain
- Neck Pain
- Weakness in Arms
- Weakness in Legs
- Difficulty with Mobility
- Balance Disturbance

ENDOCRINE
- Diabetes (Type 1 or 2)
- Thyroid Disease

PSYCHIATRIC
- Anxiety
- Depression
- Other Psychiatric Disorder
- Difficulty Sleeping
- Suicidal Thoughts
- Homicidal Thoughts
- Mood Swings

HEMATOLOGIC
- Bruises: Frequent or Easily
- Cuts that Bleed Easily
- Enlarged Lymph Nodes
- Anemia
- Blood Clots

Name & DOB: _____ Date: _____

REVIEW OF PAIN

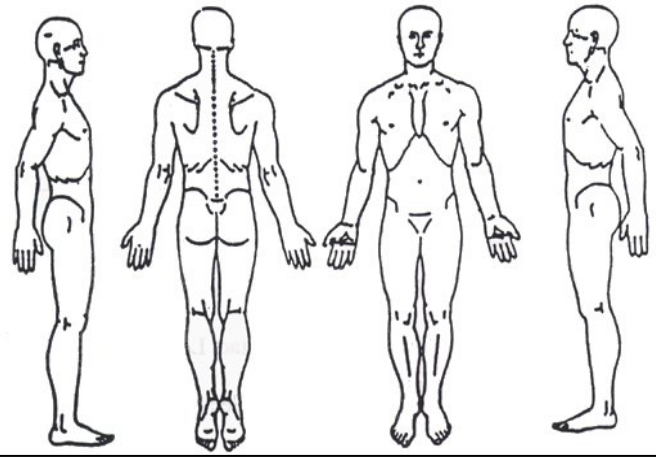
Circle your AVERAGE severity of pain on a scale of 0 (No Pain) to 10 (Severe Pain).

0 1 2 3 4 5 6 7 8 9 10

Left-Handed or Right-handed: L or R

Describe the type of pain you are experiencing *(Check all that apply)*

- ○ Aching
- ○ Numbness
- ○ Stiffness
- ○ Burning
- ○ Sharp
- ○ Swelling
- ○ Other:_____
- ○ Cramping
- ○ Shooting
- ○ Throbbing
- ○ Dull
- ○ Stabbing
- ○ Tingling



Please shade in the areas where your current pain is located

What side is your pain on? Right Middle Left

When did the pain start? _____

Please describe what happened:

_____

Is the pain constant or intermittent? Constant or Intermittent

Does anything bring on the pain? _____

Does your pain interfere with *(Please circle)*: Work Sleep Daily Routine Recreation

Other: _____

Does your pain radiate? Left or Right? _____

Activities that exacerbate your pain: Sitting Standing Walking Bending Lying Down

Other: _____

What makes your pain better? _____

Is there anything else you would like to discuss today? _____

Name & DOB: _____ Date: _____

CONSERVATIVE TREATMENTS

What conservative treatments have you tried?

Physical Therapy? Yes or No

Facility/Provider*?* _____

When/Dates? _____

How many total sessions did you attend? _____

Did this make your pain *(circle one):* Better Worse No Change

Injections? Yes or No

Facility/Provider*?* _____

When/Dates? _____

What kind of injection did you have? _____

Did this make your pain *(circle one):* Better Worse No Change

Chiropractic treatment? Yes or No

Facility/Provider? _____

When/Dates? _____

How many total sessions did you attend? _____

Did this make your pain *(circle one):* Better Worse No Change

TENS UNIT:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
ACUPUNTURE:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
BRACE:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
TRACTION UNIT:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
ANTI-INFLAMMATORIES:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
HEAT:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
ICE:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**
EXERCISE:	**Yes or No**	Did this make your pain (circle one):	**Better Worse No Change**