PATIENT QUESTIONNAIRE

Name ____________________________________ Phone (   )___________________

Address ________________________ City ________________ State _____ Zip ______

Age ________ Birthdate ___________ Sex ______Height________ Weight __________

Email _____________________________________

INSURANCE INFORMATION

Insurance Company/Carrier____

Policy #_________________________   Group # ________________________

Name on Policy (If other than self) ____

1. **What are your PRESENT complaints and symptoms? List present complaints (describe fully):**

   ____
   ____
   ____
   ____
   ____

2. **Duration of present condition: ___________ What do you believe caused this condition?**

   ____
   ____
   ____

3. **Have you ever experienced this type of complaint before?**
   (   ) Yes   (   ) No   If yes, Please describe:
   ____
   ____
   ____

4. **Do you have any congenital (from birth) factors which relate to this problem?**
   (   ) Yes   (   ) No   If yes, Please describe:

   ____
   ____
   ____

5. **Have you been treated by another doctor for this condition?**
   (   ) Yes   (   ) No   If yes, please list doctor's name, address and type of treatment received:

   ____
   ____
   ____
   ____

6. **Do you have any other conditions which the doctor should know about?**

   ____
   ____
   ____
   ____

7. **How often do you experience your symptoms?**

   1. Constantly (76%-100% of the day)
   2. Frequently (51%-75% of the day)
   3. Occasionally (26%-50% of the day)
   4. Intermittently (0%-25% of the day)

8. What describes the nature of your symptoms?

1. Sharp   4. Shooting   Other ______________________
2. Dull ache   5. Burning
3. Numb   6. Tingling

9. How are your symptoms changing?

1. Getting better
2. Not changing
3. Getting worse

10. How bad are your symptoms at their:

	None										**Unbearable**
a. Best:	0	1	2	3	4	5	6	7	8	9	10
b. Worst:	0	1	2	3	4	5	6	7	8	9	10

11. How do your symptoms affect your ability to perform daily activities?

0 1 2 3 4 5 6 7 8 9 10

No Complaints | Mild, forgotten with activity | Moderate, interferes with activity | Limiting, prevents full activity | Intense, preoccupied with seeking relief | Severe, no activity possible

12. What activities make your symptoms worse?

____

____

13. What activities make your symptoms better?

____

____

14. Who have you seen for your symptoms?

1. Medical Doctor 2. Chiropractor 3. Physical Therapist
4. No one 5.Other

a. **When and what treatment?**

____

b. **What tests have you had for your symptoms and when were they performed?**

1. X-ray *date*: ________________ 3. CT Scan *date*: ________________
2. MRI *date*:_________________ 4. Other *date*: _________________

15. Have you had similar symptoms in the past? 1. Yes 2. No

16. CHECK ANY SYMPTOMS THAT APPLY:

Past Present

( ) ( ) Headaches
( ) ( ) Neck Pain
( ) ( ) Upper Back Pain
( ) ( ) Mid Back Pain
( ) ( ) Low Back Pain

( ) ( ) Shoulder Pain
( ) ( ) Elbow/Upper Arm Pain
( ) ( ) Wrist Pain
( ) ( ) Hand Pain

( ) ( ) Hip/Upper Leg Pain
( ) ( ) Knee/Lower Leg Pain
( ) ( ) Ankle/Foot Pain

( ) ( ) Jaw Pain

( ) ( ) Joint Swelling/Stiffness
( ) ( ) Arthritis
( ) ( ) Rheumatoid Arthritis
( ) ( ) General Fatigue
( ) ( ) Muscular Incoordination
( ) ( ) Visual Disturbances
( ) ( ) Dizziness

( ) ( ) Cancer
( ) ( ) Tumor
( ) ( ) Asthma
( ) ( ) Chronic Sinusitis

Past Present

( ) ( ) High Blood Pressure
( ) ( ) Heart Attack
( ) ( ) Chest Pains
( ) ( ) Stroke
( ) ( ) Angina

( ) ( ) Kidney Stones
( ) ( ) Kidney Disorders
( ) ( ) Bladder Infection
( ) ( ) Painful Urination
( ) ( ) Loss of Bladder Control
( ) ( ) Prostrate Problems

( ) ( ) Abnormal Weight Loss/Gain
( ) ( ) Loss of Appetite
( ) ( ) Abdominal Pain
( ) ( ) Ulcer
( ) ( ) Hepatitis
( ) ( ) Liver/Gall Bladder Disorder

Other Health Problems/Issues
( ) ( )
( ) ( )
( ) ( )

Past Present

( ) ( ) Diabetes
( ) ( ) Excessive Thirst
( ) ( ) Frequent Urination

( ) ( ) Smoking/use tobacco products
( ) ( ) Drug/Alcohol Dependence

( ) ( ) Allergies
( ) ( ) Depression
( ) ( ) Systemic Lupus
( ) ( ) Epilepsy
( ) ( ) Dermatitis Eczema/Rash
( ) ( ) HIV/AIDS

Females Only
( ) ( ) Birth Control Pills
( ) ( ) Hormonal Replacement
( ) ( ) Pregnancy

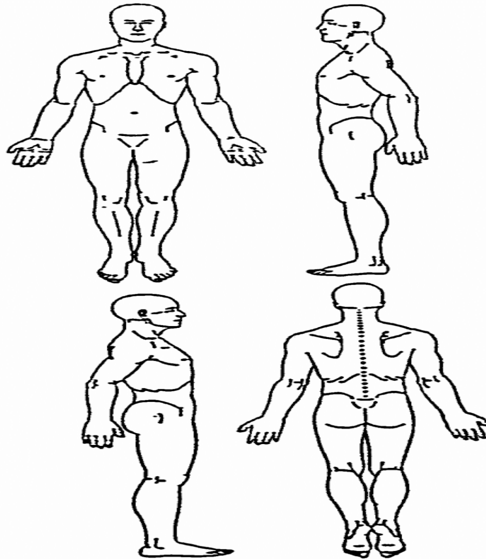
Indicate if an immediate family member has had any of the following:
( ) Rheumatoid Arthritis ( ) Heart Problems ( ) Diabetes ( ) Cancer
( ) Lupus ( ) Other _________________

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:
____
____

List all the surgical procedures you have had and the times you have been hospitalized:

____
____

Please circle any areas of pain:



EMPLOYMENT INFORMATION

17. What is your Occupation?

____

a. **If you are not retired, a homemaker, or a student, what is your current work status?**

1. Full-time 3. Self-employed 5. Off work
2. Part-time 4. Unemployed 6. Other

18. Have you lost time from work as a result of this condition?
( ) Yes ( ) No If yes, please complete this question.

a. Last day worked: ____
b. Type of employment: ____

19. Do you notice any activity restrictions as a result of this injury?
( ) Yes ( ) No if yes, please describe, in detail:

____
____
____
____

_______________________________________ ____________________
Patient Signature Date