NEW PATIENT QUESTIONNAIRE

Name ____ Date ______________

Address ____ Home Phone ________________

City ________________________ State ______ Zip __________ Work Phone ________________

Occupation (includes homemaking) _________________________ Cell Phone ________________

Employer ____ Email _____________________

Age _____ Birth Date _______________ Sex M F Marriage Status: M S W D # Children ____

Referred by ______________________________ Condition due to accident or injury? Y 6 N 6

Accident Occurred at Work? Y 6 N 6 When? ____________________________________

Auto Accident Related? Y 6 N 6 When? ____

SYMPTOM/PAIN INFORMATION

HEAD:
6 Headache
  6 entire head
  6 back of head
  6 forehead
  6 temples
  6 migraine
6 Head feels heavy
6 Loss of memory
6 Light-headedness
6 Fainting
6 Lights bother eyes
6 Loss of smell
6 Loss of taste
6 Loss of balance
6 Dizziness
6 Loss of hearing
6 Pain in ears
6 Buzzing in ears

NECK:
6 Pain in neck
6 Neck pain on movement
6 Pinched nerve in neck
6 Neck feels out of place
6 Stiff neck
6 Muscles spasms in neck
6 Grinding sounds in neck
6 Grating sounds in neck
6 Popping sounds in neck
6 Arthritis in neck

LOW BACK:
6 Low back pain
6 Low back pain is worse when:
  6 working
  6 lifting
  6 stooping
  6 standing
  6 sitting
  6 bending
  6 coughing
6 Pinched nerve in low back
6 Slipped disc
6 Low back feels out of place
6 Muscle spasms
6 Arthritis

MID BACK:
6 Midback pain
6 Pain between shoulder blades
6 Sharp stabbing pain in mid-back
6 Muscle spasms
6 Hurts to take deep breath

ABDOMEN:
6 Nervous stomach
6 Nausea
6 Gas
6 Constipation
6 Diarrhea
6 Stomach pain after meal
6 Difficult reclining after meal

SHOULDERS:
6 Pain in shoulder R L
6 Pain across shoulders
6 Bursitis R L
6 Arthritis R L
6 Can't raise arm
  6 Above shoulder level
  6 over head
6 Tension in shoulder R L
6 Muscle spasms shoulder
6 Frozen shoulder

ARM & HANDS:
6 Pain in upper arm
6 Pain in forearm
6 Pain in hands
6 Pain in fingers
6 Pinched nerve arm
6 Pinched nerve fingers
6 Feeling of pins & needles in arms
6 Feeling of pins & needles in fingers
6 Fingers go to sleep
6 Hands feel cold
6 Swollen finger joints
6 Sore finger joints
6 Arthritis in fingers
6 Loss of grip strength
6 Tennis elbow
6 Carpal Tunnel

HIPS, LEGS & FEET:
6 Pain in buttocks R L
6 Pain in hip joint R L
6 Pain down leg R L
6 Pain down both legs
6 Leg cramps
6 Pins & needles in legs R L
6 Numbness of leg R L
6 Numbness of feet R L
6 Numbness of toes R L
6 Feet feel cold
6 Cramps in feet R L
6 Sprained ankle R L
6 Swollen feet R L
6 Painful joints in toes
6 Pain in foot R L
6 Pain in knee R L

CHEST:
6 Chest pain
6 Pain around ribs
6 Shortness of breath

GENERAL:
6 Nervousness
6 Irritable
6 Depressed
6 Fatigue
6 Generally feel run-down
6 Loss of sleep
6 Loss of weight
6 Migratory pains

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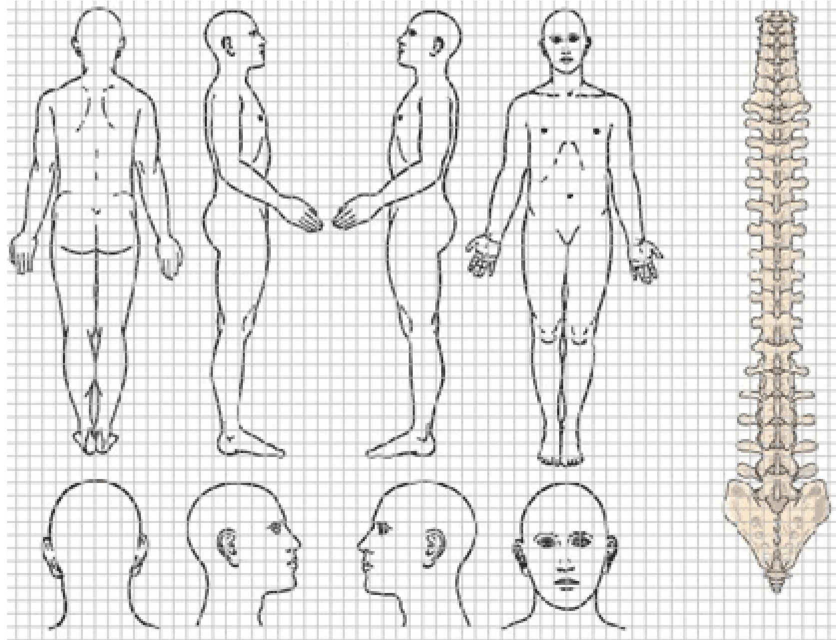
1. Please describe the health problem for which you came to our office. ________________________________

____

2. Describe the character of your symptom(s). Some words often used might include burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc. ____________________________________

____

3. Shade in the areas on the diagram where you feel discomfort or symptoms.



4. Please put a mark on the scale to show how bad your usual discomfort has been recently. If you are describing more than one symptom indicate the level of pain for each symptom.

Symptom(s)													
	No Discomfort	0	1	2	3	4	5	6	7	8	9	10	Worse Possible Discomfort
		0	1	2	3	4	5	6	7	8	9	10	

5. How long have you had this episode of symptoms? ____________________________________

6. How many times have you had a problem similar to or the same as this in the past?

6 None previously
6 1-5 episodes
6 6-10 episodes
6 More than 10 episodes
6 Single episode of continuous pain

7. When was the very first time you ever felt something similar to or the same as your current problem?

6 Less than 6 months ago
6 6 months – 1 year ago
6 1 - 5 years ago
6 5 - 10 years ago
6 10 - 20 years ago
6 More than 20 years ago

8. Did symptoms begin gradually over time or suddenly? ____________________________________

9. Since your symptoms began, have they 6 improved 6 worsened 6 stayed the same?

10. Are your symptoms constant? 6 Yes 6 No What caused your symptoms to occur (physical overuse, mental stress, accident, etc)? PLEASE BE SPECIFIC ____________________________________

____

____

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11. What posture, movement, or behavior makes your condition worse? ___________________________________

____

12. Is there any posture, exercise, movement or behavior that makes your condition better? ___________________

____

13. Is your sleep disturbed by your condition? 6 Yes 6 No

    Do you sleep on a: 6 mattress and box springs 6 waterbed 6 futon 6 other _____________________

    What is your normal sleeping position? 6 back 6 side 6 stomach 6 other ______________________

14. Are your symptoms better in the morning? 6 Yes 6 No Worse in the morning? 6 Yes 6 No

    Better in the evening? 6 Yes 6 No Worse in the evening? 6 Yes 6 No

15. Have you done anything to try to help or relieve your complaint other than medication such as 6 rest, 6 heat, 6 cold, 6 sitting, 6 lying down or 6 other? ____

    Describe ____

16. Please list whatever medications you are presently taking: ____

____

17. Do you exercise regularly? 6 Yes 6 No Please describe: 6 walking 6 running 6 swimming 6 weights

    6 yoga 6 Pilates 6 bicycle 6 elliptical 6 other ____

    How many times per week or month? ____

18. Have you seen a chiropractor for this problem? 6 Yes 6 No If yes when?___________________________

    If applicable, the doctor's name and address:____

    How much did it help?

No Improvement	1	2	3	4	5	6	7	8	9	10	Full Improvement

19. Have you seen a physical therapist for this problem? 6 Yes 6 No If yes when?_________________________

    How much did it help?

No Improvement	1	2	3	4	5	6	7	8	9	10	Full Improvement

20. Have you seen a medical doctor related to this problem? 6 Yes 6 No If yes when?_____________________

    Doctor's name and address: ____

    How much did it help?

No Improvement	1	2	3	4	5	6	7	8	9	10	Full Improvement

21. Have you had x-rays, CAT Scans, or MRI's for your condition? 6 Yes 6 No If yes when?_______________

    Name and address of facility ____

22. Does your family have a history of any health problems? ____

____

23. Do you have a history of any serious illnesses or disorders? ____

____

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24. Have you ever had any surgeries? 6 Yes 6 No If yes what kind and when?____________________________

____

25. Have you ever had serious injuries or broken bones? 6 Yes 6 No If yes what kind and when?__________

____

26. Do you have a specific diet? 6 Yes 6 No If yes what kind?____

27. Do you vitamins or herbs? 6 Yes 6 No If yes what kinds?____

____

28. Do you smoke any tobacco products? 6 Yes 6 No If yes how much and how often?____________________

29. Do you drink any alcohol? 6 Yes 6 No If yes how much and how often?_____________________________

30. Do you drink any caffeinated beverages? 6 Yes 6 No What kind(s)? _________________________________

How much and how often?____

31. Describe your physical activity during the day:
6 Seated at computer 6 Extensive telephone use

Very Physical	1	2	3	4	5	Very Sedentary

Please check the appropriate response.
If "yes", please explain in the comments section below. If you are not sure, check the "**?**" box**.**

Yes	No	**?**	
6	6	6	Do you have a past history of cancer?
6	6	6	Have you had any unexplained weight loss?
6	6	6	Does your pain improve with rest?
6	6	6	Are you over 50 years old?
6	6	6	Failure to respond to a course of conservative care (4-6 weeks)?
6	6	6	Have you had spinal pain greater than 4 weeks?
6	6	6	Prolonged use of corticosteroids (such as organ transplant Rx)?
6	6	6	Intravenous drug use?
6	6	6	Current or recent urinary tract, respiratory tract or other infection?

Yes	No	**?**	
6	6	6	History of significant trauma?
6	6	6	Immunosuppression medication &/or condition?
6	6	6	Minor trauma in person >50 years old?
6	6	6	Are you over 70 years old?
6	6	6	Do you have osteoporosis (weak bones)?
6	6	6	Acute onset urinary retention or overflow incontinence (wet underwear)
6	6	6	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
6	6	6	Saddle anesthesia (numbness in the groin region)
6	6	6	Global or progressive muscle weakness in the legs (legs give out)

____

____

Women Only:

a. Are you pregnant or think you may be pregnant? 6 Yes 6 No
b. Date of last menstrual period? ____________________________
c. Do you or have you ever suffered from any menstrual disorders? 6 Yes 6 No
If yes please describe:

I certify that I have read and understand these four pages of information. To the best of my knowledge the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Date ________________________________ Patients Signature ______________________________________

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