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 □ N □

Accident Occurred at Work? Y □ N □ When? _____

Auto Accident Related? Y □ N □ When? _____

SYMPTOM/PAIN INFORMATION

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

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

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

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

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

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

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

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

CHEST:
- □ Chest pain
- □ Pain around ribs
- □ Shortness of breath

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

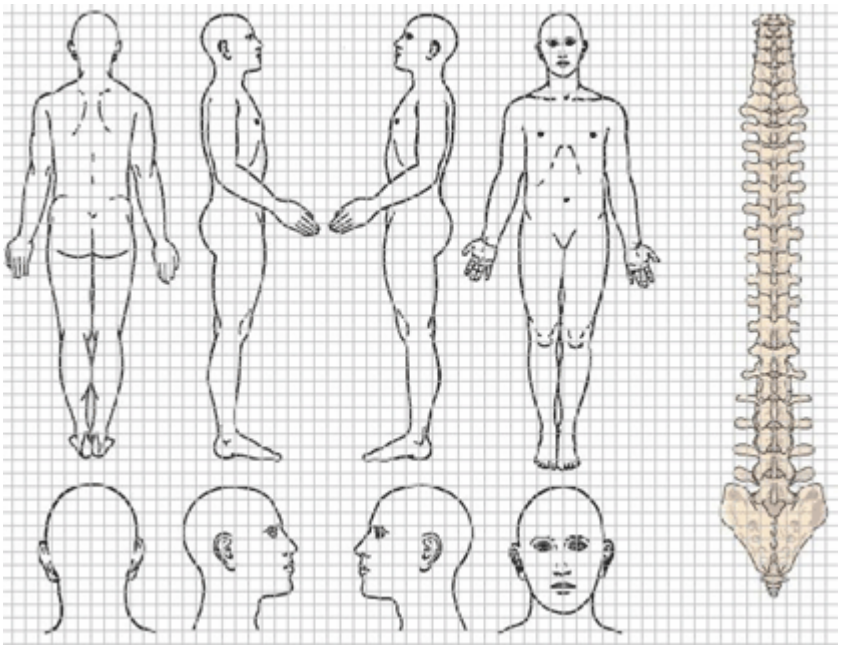
1. Please describe the health problem for which you came to our office. _____

_____

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?

□ None previously
□ 1-5 episodes
□ 6-10 episodes
□ More than 10 episodes
□ 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?

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

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

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

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

_____

_____

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? □ Yes □ No

    Do you sleep on a: □ mattress and box springs □ waterbed □ futon □ other _____

    What is your normal sleeping position? □ back □ side □ stomach □ other _____

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

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

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

    Describe _____

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

_____

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

    □ yoga □ Pilates □ bicycle □ elliptical □ other _____

    How many times per week or month? _____

18. Have you seen a chiropractor for this problem? □ Yes □ 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? □ Yes □ 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? □ Yes □ 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? □ Yes □ 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? _____

_____

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

_____

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

_____

26. Do you have a specific diet? □ Yes □ No If yes what kind?_____

27. Do you vitamins or herbs? □ Yes □ No If yes what kinds?_____

_____

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

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

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

How much and how often?_____

31. Describe your physical activity during the day:
□ Seated at computer □ 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	?		Yes	No	?	
□	□	□	Do you have a past history of cancer?	□	□	□	History of significant trauma?
□	□	□	Have you had any unexplained weight loss?	□	□	□	Immunosuppression medication &/or condition?
□	□	□	Does your pain improve with rest?	□	□	□	Minor trauma in person >50 years old?
□	□	□	Are you over 50 years old?	□	□	□	Are you over 70 years old?
□	□	□	Failure to respond to a course of conservative care (4-6 weeks)?	□	□	□	Do you have osteoporosis (weak bones)?
□	□	□	Have you had spinal pain greater than 4 weeks?	□	□	□	Acute onset urinary retention or overflow incontinence (wet underwear)
□	□	□	Prolonged use of corticosteroids (such as organ transplant Rx)?	□	□	□	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
□	□	□	Intravenous drug use?	□	□	□	Saddle anesthesia (numbness in the groin region)
□	□	□	Current or recent urinary tract, respiratory tract or other infection?	□	□	□	Global or progressive muscle weakness in the legs (legs give out)

_____

_____

Women Only:

a. Are you pregnant or think you may be pregnant? □ Yes □ No
b. Date of last menstrual period? _____
c. Do you or have you ever suffered from any menstrual disorders? □ Yes □ 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 _____