NEW PATIENT QUESTIONNAIRE

Today's Date _____

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Date of Birth _____

SS # _____

Occupation (includes homemaking) _____ Employer _____

What type of physical activity or posture does your job involve? (prolonged sitting, standing, bending, etc.)

_____

SYMPTOM/PAIN INFORMATION:

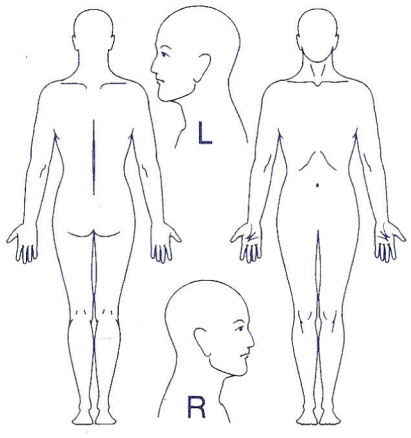
1. Please describe the health problem for which you came to our office. _____

   _____

2. Describe the character of your symptom(s). Some words often used 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.

No Discomfort | | | | | | | | | | | Worst Possible Discomfort

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?
   (Count episodes that lasted at least one day, but eventually went away completely.)

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

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 ☐ 1-5 years ago ☐ 10-20 years ago
   ☐ 6 months - 1 year ago ☐ 5-10 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? _____

If there are *any* times or positions when you do not experience your pain/discomfort (e.g., after exercising, while sleeping), please explain _____

11. What caused your symptom(s) to occur (physical overuse, mental stress, accident, etc.)? BE SPECIFIC.

_____

_____

12. What aggravates your current symptoms? _____

_____

13. Is your sleep disturbed by these symptoms? _____

14. Do you sleep on a ☐ mattress and box spring ☐ waterbed ☐ futon ☐ other _____

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

15. If you are restricted/limited in any work, home or recreational activities because of your discomfort, please describe _____

_____

16. Are your symptoms the result of an auto accident, work injury or other personal injury? _____

If you answered yes, please fill out an accident specific form, available at the desk.

17. Have you done anything to try to help or relieve your complaint, such as rest, heat, cold, aspirin, medications, sitting, lying down, or other? _____

Describe _____

18. Are you now doing corrective exercises for your present symptoms? _____

If yes, who recommended them? _____

Briefly describe the exercises/stretches you are doing. _____

_____

19. Do you participate in other exercises (aerobics, walking, jogging, etc.)? _____

If yes, what type and how many times per week/month. _____

20. Have you seen a chiropractor outside of this office for this problem? _____

If yes, whom did you see? _____ When were you seen? _____

Were x-rays or any other tests done? _____

What type of treatment was done? _____

How much did it help? [1----------10]

No Improvement Full Improvement

21. Have you seen a physical therapist or other Doctor for this problem? _____

If yes, whom did you see? _____ When were you seen? _____

Were x-rays or any other tests done? _____

What type of treatment was done? _____

How much did it help? [1----------10]

No Improvement Full Improvement

22. Have you seen a chiropractor, physical therapist osteopath, or any Doctor, for any other problems? _____

If yes, please describe. _____

23. Are you aware of any blood relatives with similar discomforts/problems? _____ No _____ Yes

Describe _____

Medical History

1. Are you now or have you suffered from the following? (Please write Past, Present, or Never in the blanks)

Arteriosclerosis	Double or Blurred Vision	Multiple Sclerosis
Asthma	Epilepsy	Polio
Arthritis	Heart Attack/Disease	Stroke
Cancer	High Blood Pressure	Ear Infections
Diabetes	Migraines	Rheumatic Fever
Dizziness/Fainting	Motion Sickness	Allergies
Anemia	Back Surgery	Influenza
HIV Infection	Pleurisy	Fatigue (Chronic)
Tuberculosis	Digestive Disorders	Sinus Trouble
Measles	Mumps	Pneumonia
Appendicitis	Thyroid Problems	TMJ
Carpal Tunnel	Venereal Disease	Low Blood Pressure
Scarlet Fever	Hepatitis	Ulcer
Kidney Disease	Depression	Drug or Alcohol Dependence
Eczema	Broken Bones	Gout
Chicken Pox		

Women Only:

a. Are you pregnant or think you may be pregnant? _____

b. Date of last menstrual period _____

c. Do you or have you suffered from any menstrual disorders? _____

If yes, please describe _____

2. Do you have any condition, disease or problem not listed above? _____

If yes, please describe _____

3. Do you smoke, or use any tobacco products? _____ If yes, how often? _____

4. Do you drink alcoholic beverages? _____ If yes, how often? _____

5. Do you drink caffeinated beverages? _____ If yes, how often? _____

6. Have you had any other serious illness/trauma (falls, accidents), surgeries or been hospitalized? _____

If yes, describe _____

7. Please list **all** medications including birth control pills, aspirin, cortisone or vitamins that you are presently taking.

_____

_____

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

_____ _____

Date Patient's Signature

Reviewed by Doctor _____ Date _____ BP _____

History Review and Significant Findings: _____

_____

_____

_____

_____