NEW PATIENT QUESTIONAIRE

Patient Name:_____**Date**: _____

Primary Care Physician: _____

Did a Physician refer you? Yes □/No□ If yes: Referring Physician: _____
If referral is other than a physician, please indicate: Friend □/Family □/Internet□/Other_____

What is the reason for your visit today?_____ How long have you had the symptoms?_____days/weeks/months/years. Are they getting worse? Yes □/ No□

*Where are your symptoms/pain?*_____

_____

What do you think is causing your symptoms/pain? _____

_____

*Do your symptoms/pain radiate? R arm, L arm, R leg, L leg, other:*_____

Did your symptoms begin with an injury? Yes □/No□
If you were injured, did the injury occur: at work□, in a motor vehicle accident□, other circumstances□: Please explain how you were injured:_____
If you were injured, are you currently involved in any lawsuits regarding this injury? Yes □/No□

Pain related questions:
*Please rate your pain on a scale from 0 (no pain) to 10 (the most severe pain you can imagine):*_____/10 *How severe is your pain at its WORST?*_____/10
How severe is your pain at its BEST?_____/10
What does your pain feel like? (Circle all that apply) Throbbing, Shooting, Stabbing, Burning, Sharp, Tingling, Numb, Tender, Pressure, Deep, Aching, Cramping, Heaviness, Other:_____

What is the pattern of your symptoms? Continuous (always present), Comes and goes, Gets worse as the day goes on

What makes your symptoms worse? Nothing, Sitting, Bending, Lifting, Twisting, Driving, Coughing, Sneezing, Standing, Walking, Lying down, Other: _____

What makes your symptoms better? Nothing, Rest, Lying down, Bending, Sitting, Medication, Ice or heat, Other, specify: ___

Do your symptoms interfere with any of the following? (Circle all that apply)
Sleep, Daily activities, Work, Relationships

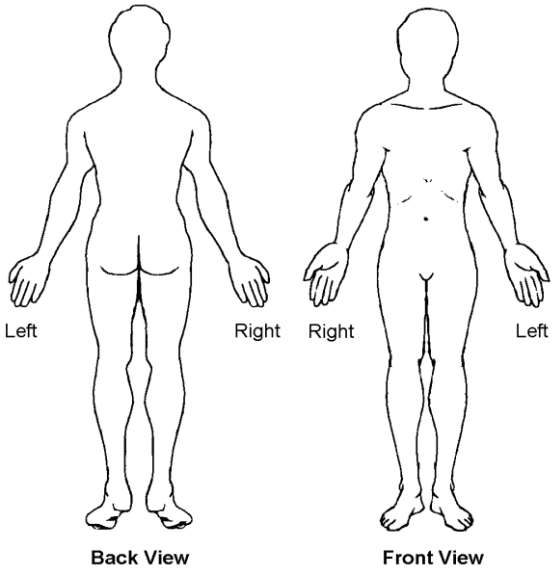
Do your symptoms make you feel: (Circle all that apply)
Depressed, Angry, Frustrated, Helpless/hopeless

Please circle any previous treatments you have had for your current symptoms: None □
Herbal remedies, Physical or occupational therapy, Work hardening, TENS unit, Chiropractor, Injections, Surgery, Counseling, Biofeedback, Acupuncture, Osteopathic Manipulation, Medications
Other: _____

Circle or list any tests you have had related to your current symptoms: None □
X-ray, CT scan, MRI, Myelogram, Bone scan, EMG, Nerve conduction, Blood tests

Using the symbols given below, mark the diagrams in the areas where you feel the described sensations in your body. Include all affected areas.
If more than one area is marked, please rank your preferred order of importance for the physician to address your problems today, using "1" for most important.

Ache	Numbness	Pins / needles	Burning	Stabbing	Other
✧✧✧	====	❍❍❍	xxxx	////	●●●



Please use the space below to describe your condition further if needed:

_____

_____

_____

_____

YOUR MEDICAL HISTORY (circle all that apply)
Allergic Rhinitis, High Blood Pressure, Arrhythmia/Murmur, Heart Attack/Angina, Asthma, COPD(lung disease), Reflux (GERD), Hepatitis, Kidney Disease, Arthritis, Stroke, Migraines, High Cholesterol, Thyroid disease, Diabetes, Skin Cancer, Cancer, HIV/AIDS, Anesthesia Problems, Enlarged Prostate
Other medical problems not listed:_____

SURGICAL HISTORY **DATE**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

FAMILY HISTORY
Please list any known medical problems:
Father: living □/deceased □ _____
Mother: living □/deceased □ _____
Siblings: _____
Children: _____

SOCIAL HISTORY

What was the highest level of education you completed? High school □/ College □/ Graduate school □
What is you marital status? Single □/ Married □/ Separated □/ Divorced □/ Widowed □
How many children do you have? _____
Do you smoke? Yes □/No□ *If yes, how many packs/ day* _____*How many years have been smoking?*_____
Do you drink alcohol? Yes □/No□ *If yes, how much and often do you drink? (e.g. 2 glasses of wine/day)* _____
Do you use recreational drugs? Yes □/No□: *If yes, please describe* _____
Do you exercise regularly? Yes □/No□: *If yes, how often?* _____

WORK HISTORY

Are you currently working? Yes □/No□: *If yes, who is your current employer:* _____

What is your occupation? _____

Are you disabled? Yes □/No□: *If yes, how long have you been disabled?* _____

What caused you to become disabled?_____

REVIEW OF SYSTEMS

Please circle any of the following problems that you are now experiencing:

Constitutional*:* weight change, weakness, fatigue, fever

Eyes*:* change in your eyeglass prescription, eye pain, tearing, double vision

Ear, Nose, Throat*:* hearing loss, nasal congestion, ringing in your ears, dizziness, sore throat

Cardiovascular*:* shortness of breath, chest pain, palpitations, ankle swelling

Respiratory*:* cough, sputum, coughing up of blood, difficulty breathing, wheezing

Gastrointestinal*:* heartburn, nausea, vomiting, abdominal pain, constipation, diarrhea, bowel incontinence, bloody stool

Genitourinary*:* pain with urination, bladder incontinence, urgency, blood in urine

Musculoskeletal*:* joint pain, stiffness, neck or backache

Skin*:* rash, lumps, itching, hair changes, nail changes

Neurological*:* headache, weakness, numbness, seizures, blackouts, memory loss, difficulty sleeping

Psychological*:* nervousness, tension, depression, anxiety

Endocrine*:* heat or cold intolerance, sweating, thirst, hunger, change in urination

Hematologic*:* easy bruising, easy bleeding

Is there any chance you could be pregnant? Yes □/No□

MEDICATIONS

Please list all prescription and non-prescription medications, vitamins and supplements you are currently taking (including dosage, frequency and indication):

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

ALLERGIES

Allergies and intolerances:(including antibiotics, local anesthetics, x-ray contrast dyes, or latex materials, shellfish, aspirin products, foods etc.)

_____

I, the undersigned, have completed these forms to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

_____ _____

Physician Signature Date