PATIENT QUESTIONNAIRE

NAME______________________________ DOB______________ DATE____________________

To ensure you receive a complete and thorough evaluation, please provide us with the following information.

1) For what medical problem have you been referred to our office?______________________________
2) How long have you had this problem?______________________________
3) Have you received any treatment for this problem? ☐ NO ☐ YES – If YES, please describe all treatment you have received.
____
4) Do you have pain? ☐ NO ☐ YES – If YES, answer the following:
   Where is the pain?______________________________
   When did the pain begin?______________________________
   Was the pain caused by an injury?______________________________
   What makes the pain worse?______________________________
   What makes the pain better?______________________________
   Is the pain sharp, dull, burning, mild, severe?______________________________
   Is the pain constant or intermittent?______________________________
   On a scale from 1 – 10 (1 – minimal, 10 – severe), rate your pain______________________________
   Please describe your pain in your own words and complete the pain drawing on the back of this paper.______________
____
5) Check if you have had any of the following tests or treatments in the past 12 months:
   ☐ EMG ☐ MRI ☐ CT Scan ☐ X-Ray ☐ Bone Scan ☐ Cortisone Injection ☐ Other:______________
6) Are you allergic to any medications? ☐ NO ☐ YES – If YES, please list the medications to which you are allergic:__________
____
7) List all current medication (prescription and non-prescription):______________________________
____
8) Please list any surgeries or illnesses for which you have been hospitalized or treated, including the approximate date and reason for the surgery or treatment:

DATE	SURGERY / TREATMENT	REASON

9) Are you currently having any problems with: ☐ Weight loss ☐ Nausea ☐ Fatigue ☐ Headache ☐ Sore throat
   ☐ Fever ☐ Earache ☐ Hearing loss ☐ Vision ☐ Rashes ☐ Dizziness ☐ Chest pain ☐ Cough ☐ Bladder function
   ☐ Swelling ☐ Bowel function ☐ Erection function ☐ Abdominal pain ☐ Depression ☐ Constipation ☐ Diarrhea
   ☐ Shortness of breath ☐ Swallowing ☐ Bleeding ☐ Numbness ☐ Balance/falling ☐ Tingling ☐ Heartburn
   Please describe each of the above problems that you have checked:______________________________
____
____
10) Have you ever been diagnosed or had problems with any of the following conditions?
   ☐ YES ☐ NO Cancer – If YES, describe what kind:______________________________

☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO	Hepatitis
☐ YES	☐ NO	Heart Problems/Pacemaker	☐ YES	☐ NO	Stroke
☐ YES	☐ NO	High blood pressure	☐ YES	☐ NO	Kidney Disease
☐ YES	☐ NO	Asthma	☐ YES	☐ NO	Anemia
☐ YES	☐ NO	Emphysema/Bronchitis/Pneumonia	☐ YES	☐ NO	Epilepsy
☐ YES	☐ NO	Chemical dependency (i.e., alcoholism)	☐ YES	☐ NO	Rheumatoid arthritis
☐ YES	☐ NO	Depression	☐ YES	☐ NO	Other arthritic conditions
☐ YES	☐ NO	Thyroid problems	☐ YES	☐ NO	TMJ problems
☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Ulcer/Stomach problems
☐ YES	☐ NO	Multiple Sclerosis	☐ YES	☐ NO	AIDS (HIV positive)

   ☐ YES ☐ NO Other:______________________________
   Please describe any condition for which you checked YES:______________________________
____
____
11) Have any of your blood relatives had any of the above conditions? ☐ NO ☐ YES – If YES, please describe:______________
____
12) Is it possible you could be pregnant? ☐ NO ☐ YES
13) Do you use tobacco products? ☐ NO ☐ YES – If YES, how many years?______________________________
14) Do you drink alcoholic beverages? ☐ NO ☐ YES – If YES, how often?______________________________
15) What is your occupation?______________________________
   When did you last work?______________________________
   Are you presently able to perform your job responsibilities? ☐ YES ☐ NO – If NO, why?______________________________
16) Are you married? ☐ NO ☐ YES Are you able to carry out your responsibilities in your home? ☐ NO ☐ YES

Patient Signature______________________________ Weight______________ Height____________________

Questionnaire reviewed with patient by: Physician Signature______________________________ Date______________

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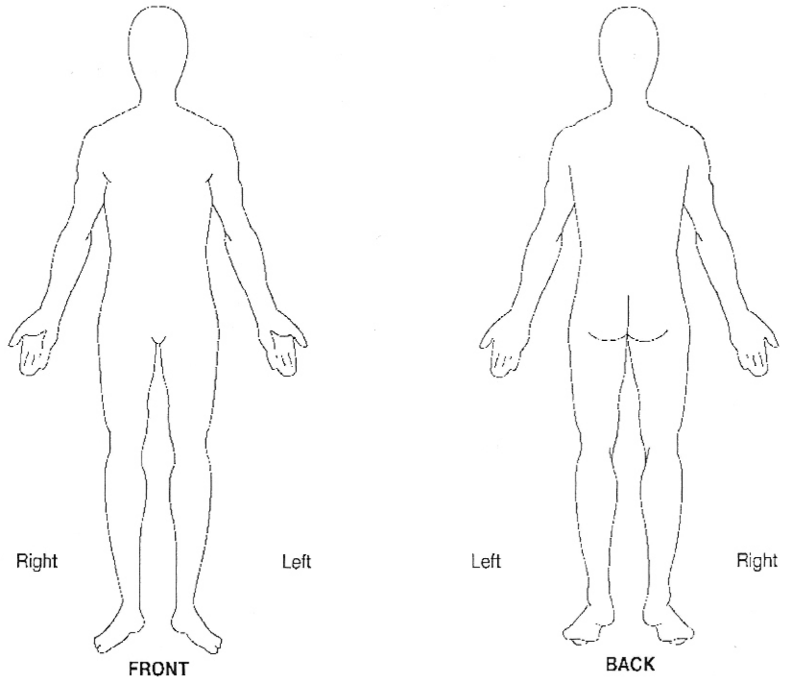
Please use the diagram below to indicate where you feel symptoms right now.

Use the following key to indicate the different type of symptoms.

KEY:
Pins and Needles = 000000
Burning = XXXXXX
Stabbing Pain = //////
Deep Ache = ZZZZZZ



Please use the three scales below to rate your pain over the past 24 hours.

Use the first line to describe your pain level right now.

Use the other scales to rate your pain at its worst and best over the past 24 hours.

Rate your pain 0 = NO PAIN 10 = EXTREMELY INTENSE PAIN

Right Now

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Worst in past 24 hours

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Best in past 24 hours

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities / positions / movements worsen your problem?____________________

____

What activities / positions / movements help your problem?____________________

____

Form reviewed with patient? ☐ YES ☐ NO

Therapist Signature______________________________ Date________________

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