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NEW PATIENT QUESTIONNAIRE

TODAY'S DATE _____

PATIENT'S DEMOGRAPHICS:

PATIENT'S FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ SEX: Male Female

HOME PHONE _____ CELL or WORK PHONE _____ E-MAIL _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN _____

PARENT/GUARDIAN DOB _____ **PARENT/GUARDIAN SS #**_____

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT NAME _____ RELATION TO PATIENT _____

PRIMARY PHONE # _____ ALTERNATE PHONE #_____

EMPLOYMENT INFORMATION:

COMPANY _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION:

INSURANCE COMPANY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ EXTENSION _____

MEMBER ID # _____ GROUP # _____

PERSONAL (PRIMARY) PHYSICIAN _____PHONE _____

ADDRESS: _____

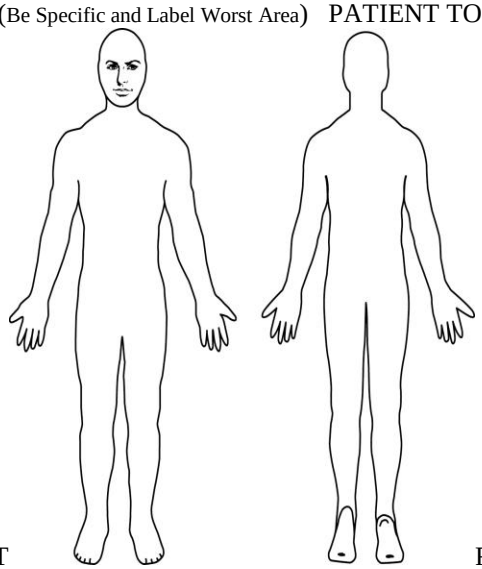
REFERRING PHYSICIAN _____ PHONE _____

ADDRESS: _____

PHARMACY: Name _____ Address: _____

PHONE_____ FAX_____

WHERE IS YOUR PAIN LOCATED? (Be Specific and Label Worst Area) PATIENT TO DRAW



RIGHT RIGHT

DATE OF INJURY _____

HOW DID YOU GET HURT? (**Please give details including dates and places**)

_____

_____

_____

WHAT BODY PARTS DID YOU HURT? _____

HAVE YOU EVER HURT THIS BODY PART BEFORE? **Yes** **No** HOW: _____

WHO **FIRST** TREATED YOU, AND WHERE? _____

WHO HAS TREATED YOU SINCE? _____

_____

CHARACTER OF YOUR PAIN *PLEASE CIRCLE ALL THAT APPLY & THE LOCATION IT OCCURS:*

CONTINUOUS (ALL DAY): DULL SHARP ACHING THROBBING SHOOTING RADIATING BURNING TINGLING NUM HOT WHERE:_____

INTERMITTENT (ON & OFF) DULL SHARP ACHING THROBBING SHOOTING RADIATING BURNING TINGLING NUMB HOT WHERE:_____

OCCASIONALLY: DULL SHARP ACHING THROBBING SHOOTING RADIATING BURNING TINGLING NUMB HOT WHERE:_____

WHAT MAKES YOUR **PAIN WORSE**: Sitting Standing **Bending**: Forward or Back Walking Lying Flat Driving

How Long Can You Now: Sit _____min. Stand _____min. Walk _____min. Run _____min.

WHAT MAKES YOUR **PAIN BETTER**: Lying Down Walking Ice Heat PT CHIRO Massage Medications

Other_____

DOES THE PAIN **LIMITS** YOUR **ACTIVITIES OF DAILY LIVING**? YES NO

IF YES, WHAT PERCENT OF THE DAY? 10% 25% 50% 75% 100%

WHAT CAN YOU **NOT** DO OR HAVE **DIFFICULTY DOING** NOW?

Self Care:	Showering	Brushing Hair	Brushing Teeth	Putting on cloths	
Communication:	Speaking	Writing	Typing	Talking on Phone	
Physical Activity:	Walking stairs	Walking	Standing	Sitting	Exercise
Sensory Function:	Hearing	Seeing	Feeling things	Tasting	Smelling
Hand Activity:	Lifting	Pulling/Pushing	Grasping	Turning pages	Holding things
Travel:	Driving a car	Turning head to look	Pain with sitting	Pain with bumps in the road	
Sexual Function:	Performing	Erection	Orgasm	Enjoying	Pain During / After

DOES THE PAIN AFFECT YOUR SLEEP? YES NO

IF YES, PLEASE DESCRIBE YOUR SLEEPING HABITS: _____

DO YOU FEEL **DEPRESSED**? YES NO **DID YOU FEEL** DEPRESSED **BEFORE** YOUR INJURY? YES NO

DO YOU HAVE ANY THOUGHTS OF DOING HARM TO YOURSELF OR OTHERS? YES NO

WHAT TREATMENTS HAVE YOU HAD?

	DATES DONE	DID THIS HELP?	
PHYSICAL THERAPY	_____	YES	NO
CHIROPRACTIC THERAPY	_____	YES	NO
HEAT TREATMENT	_____	YES	NO
ICE TREATMENT	_____	YES	NO
ACUPUNCTURE	_____	YES	NO
EPIDURAL INJECTIONS	_____	YES	NO
FACET INJECTIONS	_____	YES	NO
TRIGGER POINT INJECTIONS	_____	YES	NO
JOINT INJECTIONS	_____	YES	NO
PSYCHOLOGISTS	_____	YES	NO NAME _____ PHONE _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSE	TABLETS PER DAY	PRESCRIBED BY (Dr.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DO YOU TAKE **BLOOD THINNERS**? NO YES (DRUG NAME AND DOSE) _____

ALLERGIES/INTOLERANCE: DO YOU HAVE ANY **ALLERGIES TO MEDICATIONS**? NO YES

LIST DRUGS AND TYPE OF REACTIONS_____

PAST MEDICAL PROBLEMS HISTORY: (Circle all conditions you have or had in the past)

HEART ATTACK	ASTHMA	PROSTATE PROBLEM	ARTHRITIS
HEART DISEASE	DIABETES	STOMACH ULCER	INTESTINAL PROBLEMS
ANGINA (CHEST PAIN)	CANCER	PREGNANCY (X__)	C-SECTIONS (X___)
STROKE	LIVER PROBLEMS	SEIZURES	OTHERS: _____
HIGH BLOOD PRESSURE	TUBERCULOSIS	KIDNEY PROBLEMS	_____
DEPRESSION	LUNG PROBLEMS	BLEEDING PROBLEMS	PREVIOUS INJURIES: DATE_____
THYROID PROBLEMS	ANXIETY	SLEEPING DIFFICULTIES	WHAT BODY PART? _____

SURGERIES YOU HAVE HAD:

SURGERY	DATE (Most Recent First)	PHYSICIAN
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS YOU HAVE HAD:

DATE (Most Recent First)	REASON	HOSPITAL (Name and Location)
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: (i.e., Joint/Back Problems, Arthritis, Cancer, Lung Problems, Heart Disease, etc.)

Please List conditions on the lines provided

Mother:	Alive	Deceased	_____	_____
Father:	Alive	Deceased	_____	_____
Children:	Alive	Deceased	_____	_____
Siblings:	Alive	Deceased	_____	_____
Maternal Uncle:	Alive	Deceased	_____	_____
Maternal Aunt:	Alive	Deceased	_____	_____
Paternal Uncle:	Alive	Deceased	_____	_____
Paternal Aunt:	Alive	Deceased	_____	_____
Paternal Grandfather:	Alive	Deceased	_____	_____
Paternal Grandmother:	Alive	Deceased	_____	_____
Maternal Grandfather:	Alive	Deceased	_____	_____
Maternal Grandmother:	Alive	Deceased	_____	_____

SOCIAL HISTORY:

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPERATED

CHILDREN? HOW MANY? _____ HOW MANY LIVE WITH YOU? _____

SPECIAL DIET? VEGETARIAN FLEXITARIAN LACTO-OVO PESCATARIAN VEGAN RAW MICROBIOTIC

EDUCATION LAST GRADE COMPLETED: _____

TOBACCO – PACKS/DAY_____ PRESENTLY or _____ years SINCE YOU QUIT

ALCOHOL – DRINKS / DAY or WEEK _____ WHAT? _____

ACTIVITIES / EXERCISE YOU DID PRIOR TO YOUR INJURY _____

OCCUPATION _____

BRIEFLY DESCRIBE WHAT YOU DO AT WORK: _____

STREET DRUGS or PAST DRUG DEPENDENCY? YES NO WHAT? _____

ROS - DO YOU HAVE ANY OF THE FOLLOWING?

CHEST PAIN OR PRESSURE	EASY BRUISING	RECENT BLEEDING	PROBLEMS WITH URINATION
SHORTNESS OF BREATH	ABDOMINAL PAIN	CONSTIPATION	INTOLERANT TO COLD/HEAT
COUGH	DIZZINESS	DIARRHEA	NAUSEA
ANKLE SWELLING	FAINTING	VISION CHANGES	WEAKNESS

OTHERS _____

INITIAL VITAL SIGNS:

Height_____ Weight_____

PAIN LEVEL AT ITS BEST (when at rest) 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL AT ITS WORST (when active) 1 2 3 4 5 6 7 8 9 10

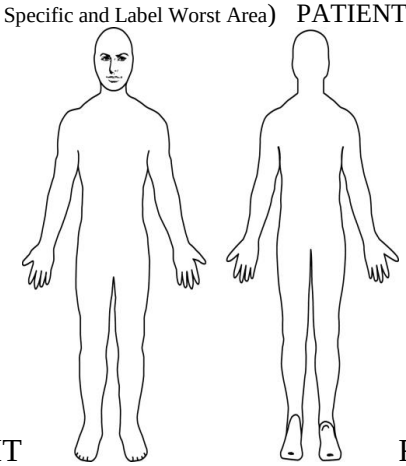
MILD MODERATE SEVERE

PRIMARY PAIN LOCATIONS: _____

IMPORTANT: In Order to properly take care of you, we need to have an understanding how you were before your current problem(s).

PLEASE DESCRIBE IF YOU HAD ANY SYMPTOMS BEFORE

WHERE IS YOUR PAIN LOCATED? (Be Specific and Label Worst Area) PATIENT TO DRAW



RIGHT RIGHT

PAIN LEVEL 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE

Describe how the pain affected your life, if any, before this episode:

_____

_____

_____

_____

TO OUR PATIENTS:

AUTHORIZATION TO RELEASE MEDICAL RECORDS INFORMATION: I HEREBY AUTHORIZE THE DOCTOR RENDERING SERVICE TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

DATE _____ PATIENT SIGNATURE _____