♦ ***Patient Questionnaire*** ♦

*Part of a Confidential Medical Record*

(Please answer all questions as completely as possible)

♦ **Name** ____________________________________________

First Middle Last

♦ **Social Security #** ________/________/________ ♦ **Date of Birth** ______/______/______

Month Day Year

♦ **Why are you here today?** ____________________________________________

____________________________________________

♦ **Draw with an "X" the level of pain you have today:**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | More Intense | | | "Take Me To The Hospital" | |

♦ **What makes your problem worse?** (Check all that apply)

❑ Sitting ❑ Standing ❑ Walking ❑ Bowel Movements ❑ Sleeping ❑ Bending

❑ Fatigue ❑ Housework ❑ Sexual Relations ❑ Working ❑ Reaching ❑ Lifting

♦ **What makes your problem better?** ____________________________________________

♦ **Are you taking any pain pills?** ❑ Yes ❑ No ♦ **What?** ______________________

♦ **Did you take any medication today?** ❑ Yes ❑ No ♦ **What?** ______________________

♦ **Have you been to an emergency room for this condition?** ❑ Yes ❑ No

Where? ______________________ When? ______________________

♦ **Have you had any of the following for this condition?** ( Check all that apply):

❑ X-ray ❑ MRI ❑ CT Scan ❑ Myelogram ❑ EMG ❑ Injections

♦ **What kinds of injections did you have?** ____________________________________________

- **List all the doctors you have seen for your present condition:**

| | Name | Specialty | Treatment | Date |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

- **Have you had physical therapy for this condition?** ❑ Yes ❑ No

  Where?______________________ How many visits?______________________

  How many weeks?______________________ Therapists Name?______________________

- **Check all that apply:** ❑ Hot Packs ❑ Cold Packs ❑ Ultrasound ❑ Traction

  ❑ Massage ❑ Whirlpool ❑ TENS ❑ Aquatic Therapy ❑ Exercise ❑ Weights

  ❑ Treadmill ❑ Bike ❑ Myofascial Release ❑ Biofeedback ❑ Yoga

- **What was most helpful?**______________________ ♦ **Least helpful?**______________________

- **What effect did physical therapy have on your condition?**

  ❑ Improved Worsened ❑ No Change

- **Do you presently have a regular exercise program?** ❑ Yes ❑ No

- **If yes, how often do you exercise?** **What type of exercise?** ______________________

  ❑ 1 time a week ❑ 2 times a week ❑ 3 times a week ❑ More than 3 times a week

- **Have you seen a Chiropractor for your present condition?** ❑ Yes ❑ No ♦**Who?**______________

- **Have you had Acupuncture for your present condition?** ❑ Yes ❑ No

- **Have you had surgery for your present condition?** ❑ Yes ❑ No

  Date(s)______________________Type of Surgery:______________________

- **Have you ever had a complaint or problem like this before?** ❑ Yes ❑ No

- **Do you feel all of your questiions regarding this condition have been previously addressed?**

  ❑ Yes ❑ No

- **If no, please comment:** ______________________

## *Past Medical History*: **Before this problem, have you ever had:** (Check all that apply)

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bladder Problems
- ❑ Bowel Problems
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug Addition
- ❑ Drug Allergies (If so name of drug?____________________)
- ❑ Extremity Injury (If so what limb? ❑ Arm ❑ Leg)
- ❑ Gallstones
- ❑ Headaches
- ❑ Head Injury
- ❑ Heart Diseas
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Lung Disease
- ❑ Psychiatric Disease or Evaluation
- ❑ Seizures
- ❑ Spinal Injury
- ❑ Stroke
- ❑ Thyroid
- ❑ Ulcers

♦ **Have you ever been a victim of physical, mental or sexual abuse?** ❑ Yes ❑ No

## *Family History*:

♦ **Has anyone in your family ever had any of the following conditions?**
Indicate which person(s) had (have) the condition using the following key. Please check all that apply:

**GM** = Grandmother **GF** = Grandfather **F** = Father **M** = Mother **S** = Sibling **C** = Child

- ❑ Anemia _____
- ❑ Arthritis _____
- ❑ Asthma _____
- ❑ Back Injury _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Substance Abuse (Alcohol, Drugs. . )_____
- ❑ Gallbladder Disease _____
- ❑ High Blood Pressure _____
- ❑ Headaches _____
- ❑ Heart Disease _____
- ❑ Head Injury _____
- ❑ Hepatitis _____
- ❑ Lung Disease _____
- ❑ Seizures _____

## *Social History*: Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow

♦ **Do you have any children?** ❑ Yes ❑ No Ages________________________________

♦ **Do you smoke cigarettes?** ❑ Yes ❑ No # _____packs per day # of years _________

♦ **Do you drink wine/beer?** ❑ Yes ❑ No ♦ **How much?** ❑ 1 a day ❑ 2 a day ❑ More

♦ **Do you drink alcohol?** ❑ Yes ❑ No ♦ **How much?** ❑ 1 a day ❑ 2 a day ❑ More

## *Job Related History:*

♦ **Are you working?** ❑ Yes ❑ No ♦ **If not, what was your last day of work?**____________
Date

♦ **When were you able to return to work?** ♦ **Full Duty?**__________ ♦ **LightDuty?**__________
Date Date

## *ob Related History Continued:*

- **Have you participated in a Vocational Rehabilitation Program?** ❑ Yes ❑ No
- **If so, what type of program?** ______________________________
- **Describe your occupation?** ______________________________
- **Describe your job duties:** ______________________________
- **Do (did) you like your job?** ❑ Yes ❑ No
- **How long have (had) you been at this job?** _____Years _____Months
- **Circle the highest level of education completed:** High School College MA PhD Other

## *Other:*

- **Do you need assistance with:** (check all that apply)

  ❑ Dressing ❑ Toileting ❑ Bathing ❑ Walking ❑ Driving ❑ Housework

- **Has your weight changed in the past year?** ❑ Yes ❑ No
- **How much did you gain or lose?** # of lbs____________
- **Do you now have or have you had a problem(s) with:**

  ❑ Concentration ❑ Nervous or easily upset ❑ Anxiety ❑ Feeling sad and lonely

  ❑ Suicidal feelings ❑ Appetite ❑ Frequent Mood Swings ❑ Fatigue

- **Do you have problems sleeping?** ❑ Yes ❑ No
- **How many times do you awaken at night?** ❑ 1 time ❑ 2 times ❑ 3 times ❑ More
- **Is this due to your problem?** ❑ Yes ❑ No

- **Circle which position makes your condition feel worse.** (Can be more than one)

  Lying on your stomach    Lying on your back    Sitting    Standing    Walking

- **Underline which position makes your condition feel best.** (Can be more than one)

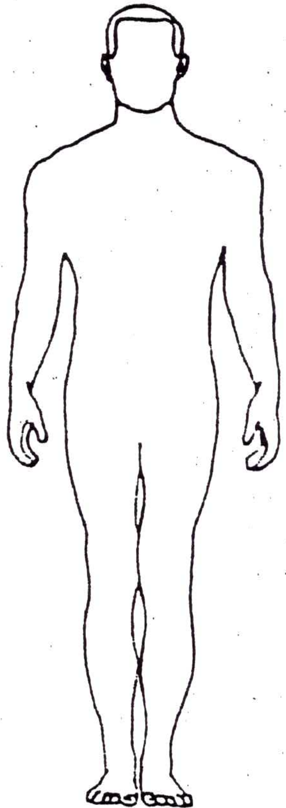
  Lying on your stomach    Lying on your back    Sitting    Standing    Walking

## *Pain Diagram:*

- **On the diagram, circle the location(s) where your pain is the worst.**
- **Using the symbols given below, mark the areas on your body where you feel the described sensations.**
- **Include all affected areas.**

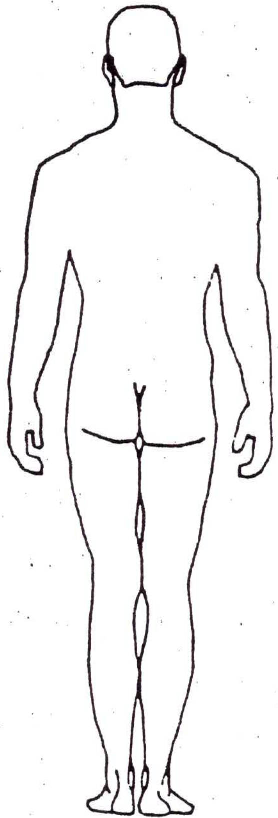
| Aching | Numbness | Pins & Needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| A A A A | N N N N N | P P P P P | B B B B B | S S S S S | . . . . . |

**Front**



**Right** **Left**

**Back**



**Left** **Right**