

CONFIDENTIAL PATIENT QUESTIONNAIRE

DATE _____
LEGAL NAME _____ DOB _____ AGE _____ SEX _____
ADDRESS _____ SS# _____
CITY, STATE _____ ZIP _____ HOME PHONE _____
E-MAIL _____ WORK PHONE _____
REFERRED BY? Name: _____ Television Newspaper Phonebook Web Site Other

Main symptom/condition: _____

*Pain Quality: dull deep sharp stabbing radiating aching burning

Rate pain: Zero represents NO pain, ten represents SEVERE pain. **Rate** your pain level, when it is at its worst, by circling number:

PAIN LEVEL (circle number)	0	1	2	3	4	5	6	7	8	9	10
-----------------------------------	---	---	---	---	---	---	---	---	---	---	----

None ---- Mild pain ----- Moderate pain ----- Severe pain -----

Have you had this or similar conditions in the past? Yes ___ No ___

Symptoms radiate from my: _____ to my _____, on the () right () left side.
(write: neck, shoulder, upper arm, elbow, wrist, hand, fingers, etc. as applicable).

*How do you describe your symptoms? mild moderate moderate-to-severe severe

*How long have you had this current condition/symptom? _____

*Things that give me relief: bending/stooping getting off feet heat ice manipulation massage
 movement non-prescription medications padding of the area physical activity pressure rest
 having shoes on having shoes off sitting soaking standing support brace walking

Things that make it feel worse: bending/stooping coughing driving deep breathing joint use lifting
 movement extreme motion being on feet physical activity pressure resting shoes on shoes off
 sitting sneezing standing straining twisting walking walking up stairs weight bearing

Is the condition getting progressively worse? Yes ___ No ___ constant ___ comes and goes ___

This condition interferes with: daily routine ___ normal lifestyle ___ sleep ___ work ___

What caused your current condition/symptoms? unknown repetitive injury lifting fall auto accident
 twisting recreational activity sports injury sprain strain bicycle jogging handtools other

*Have you been treated for this condition? Yes ___ No ___ Describe: _____

*Do you have any associated symptoms with this condition? (fatigue, ache, shortness of breath, etc.)
Describe: _____

***Past History:**

List past surgeries & dates: _____

List past illnesses & dates: _____

List past injuries/fractures & dates: _____

List past treatments & dates: _____

Current medications: _____

*Does anyone in your immediate family have any similar conditions? yes ___ no ___ mom ___ dad ___ brother ___ sister ___

*Education: high school college post graduate

Exercise: none frequent and heavy infrequent limited occasional regular

Family status: married single divorced widowed ***Number of children:** _____

HIV exposure: none HIV-positive unknown possible

Dental care: limited none regular dentures

Eye care: limited none regular require corrective lenses

Physical examination: irregular never regular

Do you take vitamins? yes no Describe: _____

Occupation: _____

Race: African-American American Indian Caucasian Hispanic Asian Other _____

Do you drink alcohol? Yes ___ No ___ Is it a problem? Yes ___ No ___

Do you use drugs? Yes ___ No ___ Is it a problem? Yes ___ No ___

Do you smoke tobacco? Yes ___ No ___

Do you chew tobacco? Yes ___ No ___

Do you have a prescription drug addiction? Yes ___ No ___

Work environment: Are you exposed to? lung pollutants repetitive injury temperature extremes
 constant sitting constant standing heavy typing/data entry heavy lifting stress

(PLEASE TURN PAPER OVER TO OTHER SIDE)

Review of Systems

Musculoskeletal:

Painful joints: fingers L __ R __ hand L __ R __ wrist L __ R __ elbow L __ R __
 shoulder L __ R __ hip L __ R __ knee L __ R __ ankle L __ R __ foot L __ R __

Stiff joints: fingers L __ R __ hand L __ R __ wrist L __ R __ elbow L __ R __

shoulder L __ R __ hip L __ R __ knee L __ R __ ankle L __ R __ foot L __ R __

Abnormal posture: yes no

Arthritis: fingers L __ R __ hand L __ R __ wrist L __ R __ elbow L __ R __

shoulder L __ R __ hip L __ R __ knee L __ R __ ankle L __ R __ foot L __ R __

Muscle weakness: hand L __ R __ forearm L __ R __ upper arm L __ R __ shoulder L __ R __

upper leg L __ R __ lower leg L __ R __ foot L __ R __

Night cramps: yes no

Recent trauma or injury: yes no

Spine problems: neck L __ R __ between shoulder blades L __ R __ low back L __ R __

Sprains: fingers L __ R __ hand L __ R __ wrist L __ R __ elbow L __ R __ shoulder L __ R __

hip L __ R __ knee L __ R __ ankle L __ R __ feet L __ R __

Swelling: fingers L __ R __ hand L __ R __ wrist L __ R __ elbow L __ R __

shoulder L __ R __ hip L __ R __ knee L __ R __ ankle L __ R __ foot L __ R __

Neurological:

equilibrium problem hearing problem speech difficulty vision problem convulsions/seizures

difficulty walking involuntary twitches motor skill loss stroke paralysis numbness

loss of bladder control sensitive to heat/cold sweating dizziness headaches memory loss fainting

head trauma sciatica multiple sclerosis

Skin:

skin color changes skin eruptions eczema. psoriasis scar tissue hot or warm areas abnormal hair loss

Constitutional:

fatigue fever weight gain weight loss allergies cancer depression diabetes epilepsy hepatitis

nervousness asthma emphysema ulcers stomach pain painful urination prostate trouble Parkinson's

Female:

lumps in breast hot flashes irregular cycles menstrual cramps are you pregnant? yes no maybe

Cardiovascular:

chest pain leg cramps cold extremities cough congestive heart failure difficult breathing heart attack

hypertension orthostatic hypotension phlebitis heart rhythm disturbance high cholesterol levels

Hematological:

anemia bleeding varicose veins

Have you ever had chiropractic care? yes no Date: _____

Name of regular medical physician _____

Date of last: spinal exam _____ spinal x-ray _____ chest x-ray _____ blood test _____

Insurance company name(s): _____

Policy # _____

Note: Insurance coverage can sometimes be different than anticipated. The patient is responsible for all costs incurred at this office. We will file the insurance information for you. Your insurance company may pay us here directly. Your payment portion is due when that insurance payment is received. Your account must remain current for care to continue.

PATIENT'S SIGNATURE: _____ DATE: _____