Confidential Patient Questionnaire

Date_____
Legal Name_____DOB_____Age_____Sex____
Address_____City_____State_____Zip_____
SS#_____Home Phone#_____Work#_____Cell#_____
E-mail_____
Referred By? Name:_____ ☐ Newspaper ☐ Website ☐ Other

Main symptom/condition:_____
Pain Quality: ☐Dull ☐Deep ☐Sharp ☐Stabbing ☐Radiating ☐Aching ☐Burning ☐Numbness
Rate the pain: Please rate your pain level, <u>when it is at its worst,</u> by selecting a number
(0 represents NO pain, 10 represents SEVERE pain)

PAIN LEVEL (select number): ☐ 0 None ☐ 1 ----- ☐ 2 Mild pain ☐ 3 ----- ☐ 4 ☐ 5 Moderate pain ☐ 6 ----- ☐ 7 ☐ 8 Severe pain ☐ 9 --- ☐ 10

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, getting off feet, heat, ice, etc.):_____
Things that make me feel worse (bending, coughing, physical activity, etc.):_____
Is the condition getting progressively worse? ☐Yes ☐No ☐Constant ☐Comes and goes
This condition interferes with my ability to:_____
What caused your current condition/symptoms? ☐unknown ☐repetitive injury ☐lifting ☐fall ☐twisting ☐auto accident ☐recreational activity ☐sports injury ☐sprain ☐strain ☐other
Have you been treated for this condition before? ☐Yes ☐No Describe:_____
Do you have any associated symptoms with this condition? (fatigue, aches, shortness of breath, etc.)
Describe:_____

Past History:

List past illnesses & dates:_____
List past injuries/fractures & dates:_____
List past surgeries & dates:_____
List past treatments & dates:_____

Education: ☐High School ☐College ☐Post Graduate
Exercise: ☐None ☐Occasional ☐Regular ☐Frequent and heavy
HIV exposure: ☐None ☐HIV-positive ☐Unknown ☐Possible

Dental care: ☐None ☐Limited ☐Regular ☐Dentures
Eye care: ☐None ☐Limited ☐Regular ☐Glasses
Physical examination: ☐Never ☐Irregular ☐Regular
Current medications:_____
Do you take vitamins? ☐Yes ☐No Describe:_____
Occupation:_____
Work environment: Are you exposed to? ☐ lung pollutants ☐repetitive injury ☐extreme temperatures ☐ constant sitting ☐constant standing ☐heavy typing/data entry ☐ heavy lifting ☐stress
Race: ☐African-American ☐Asian ☐Caucasian ☐Hispanic Other:_____
Does anyone in your immediate family have any similar conditions? ☐Yes ☐No Who?_____
Family status: ☐Married ☐Single ☐Divorced ☐Widowed ***Number of children:**_____
Do you smoke tobacco? ☐Yes ☐No Do you chew tobacco? ☐Yes ☐No
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 have a prescription drug addiction? ☐Yes ☐No

(PLEASE TURN PAPER OVER TO OTHER SIDE)

Review of Systems

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

Neurological:

☐equilibrium problem ☐hearing problem ☐speech difficulty ☐vision problem ☐convulsions/seizures ☐stroke
☐difficulty walking ☐involuntary twitches ☐motor skill loss ☐paralysis ☐numbness ☐loss of bladder control
☐sensitive to heat/cold ☐sweating ☐dizziness ☐headaches ☐memory loss ☐fainting ☐head trauma ☐sciatica
☐multiple sclerosis ☐peripheral neuropathy

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

Lymphatic/Hematological:

☐anemia ☐bleeding ☐varicose veins

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

Integumentary:

☐skin color changes ☐skin eruptions ☐eczema ☐psoriasis ☐scar tissue ☐hot/warm areas ☐abnormal hair loss

Female:

☐lumps in breast ☐hot flashes ☐irregular cycles ☐menstrual cramps
Pregnant? ☐Yes ☐No ☐Maybe

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 SIGNATURE:_____ DATE:_____