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 Ep zpv wbqf @☐Zf t ☐Op
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

Piercings: ☐Ear? How many:_____ ☐Body? Location:_____

Dental: ☐Amalgam fillings? Location(s):_____

☐Other dental problems (gingivitis, root canals, crowns, etc.)? Describe:_____

_____

Other diagnosed conditions:_____

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_____

PATIENT SIGNATURE:_____ DATE:_____