PATIENT QUESTIONAIRE

♦♦PLEASE ANSWER ALL QUESTIONS AS BEST AS POSSIBLE. THIS WILL HELP SPEED UP YOUR VISIT AND PROVIDE BETTER CARE. THANK YOU.♦♦

NAME:_____TODAY'S DATE:_____

DATE OF COMPLAINT/INJURY: _____

WHAT PART IS PAINFUL AND/OR INJURED:_____

WHICH SIDE: LEFT RIGHT BOTH (PLEASE CIRCLE ONE)

BRIEF HISTORY ON HOW COMPLAINT OR INJURY OCCURRED: _____

_____

_____

_____

PREVIOUS TREATMENT AND CARE FOR THIS INJURY/COMPLAINT: for example…..
(X-RAYS, MRI'S, INJECTIONS, TESTS AND SPEACIALISTS)

_____

_____

_____

HAVE YOU HAD A PREVIOUS INJURY OR COMPLAINT IN THIS AREA? IF SO PLEASE DESCRIBE:

_____

_____

_____

HAVE YOU LOST TIME FROM WORK BECAUSE OF THIS COMPLAINT/INJURY?
YES: _____ NO_____

YOUR PRESENT OCCUPATION: _____

SPORTS/LEISURE ACTIVITIES: (GOLF, TENNIS, SKIING ETC……)_____

_____

LEVEL OF ACTIVITY: LOW MODERATE HIGH (PLEASE CIRCLE ONE)

NAME:_____ DATE_____

GENERAL HEALTH: (CIRCLE ONE) GOOD FAIR POOR

YES_____NO_____HAVE YOU EVER BEEN SERIOUSLY ILL?
YES_____NO_____HAVE YOU EVER BEEN HOSPITALIZED?
YES_____NO_____HAVE YOU HAD SURGERY?
WHEN_____
WHAT KIND?_____

HAVE YOU EVER HAD:

YES_____NO_____CANCER
YES_____NO_____HEART TROUBLE
YES_____NO_____DIFFICULTY WITH BREATHING
YES_____NO_____LUNG DISEASE (for instance: pneumonia, asthma or emphysema)
YES_____NO_____JAUNDICE
YES_____NO_____DIABETES
YES_____NO_____FAINTING SPELLS
YES_____NO_____ALLERGIES TO MEDICATIONS (if yes, what medications and type of reaction; rash, swelling, etc...)_____
YES_____NO_____RHEUMATIC FEVER
YES_____NO_____HIGH BLOOD PRESSURE
YES_____NO_____ANEMIA OR BLEEDING PROBLEMS
YES_____NO_____OTHER SERIOUS HEALTH PROBLEMS: WHAT_____
_____

DO YOU:

YES_____NO_____TAKE MEDICATION REGULARLY (including birth control pills)_____
_____

YES_____NO_____SMOKE_____PKG/DAY
YES_____NO_____DRINK ALCOHOL SOCIALLY OCCASIONALLY RARELY

HAVE YOU EVER:

YES_____NO_____BROKEN BONES (if so, which ones and when)_____
YES_____NO_____HEAD INJURIES WHEN_____
YES_____NO_____NECK INJURIES WHEN_____
YES_____NO_____BACK INJURIES WHEN_____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY HAD:

YES_____NO_____CANCER

YES_____NO_____HEART DISEASE

YES_____NO_____LUNG DISEASE, TB, ETC...

YES_____NO_____DIABETES

HEIGHT:_____WEIGHT_____RIGHT/LEFT HANDED_____