

Patient Questionnaire

Name: _____

DOB _____ Age _____

Primary Care Physician _____

Phone# _____ Fax# _____

Who referred you to this office? _____

TODAY'S DATE: _____ Current Height _____ Weight _____

Why are you being seen today? _____

Date of onset pain/injury _____ How did your symptoms start? fall accident gradual?

Duration of symptoms: _____ months / years Are the symptoms getting better worse?

Is the pain principally in the neck/arms or back/legs or no pain?

Do you have any numbness: yes no Where?

Do you have any weakness: yes no Where?

Any bowel or bladder dysfunction? _____

Any numbness between your legs in your perineum(private area)? _____

What treatment have you received thus far for this condition?

Physical therapy yes no

Brace yes no

Epidural steroid injection yes no

Spine surgery yes no

Other, please describe

Are you currently working? yes no Retired? : yes no

Present Occupation _____

Are you on disability? yes no If yes, for what condition _____

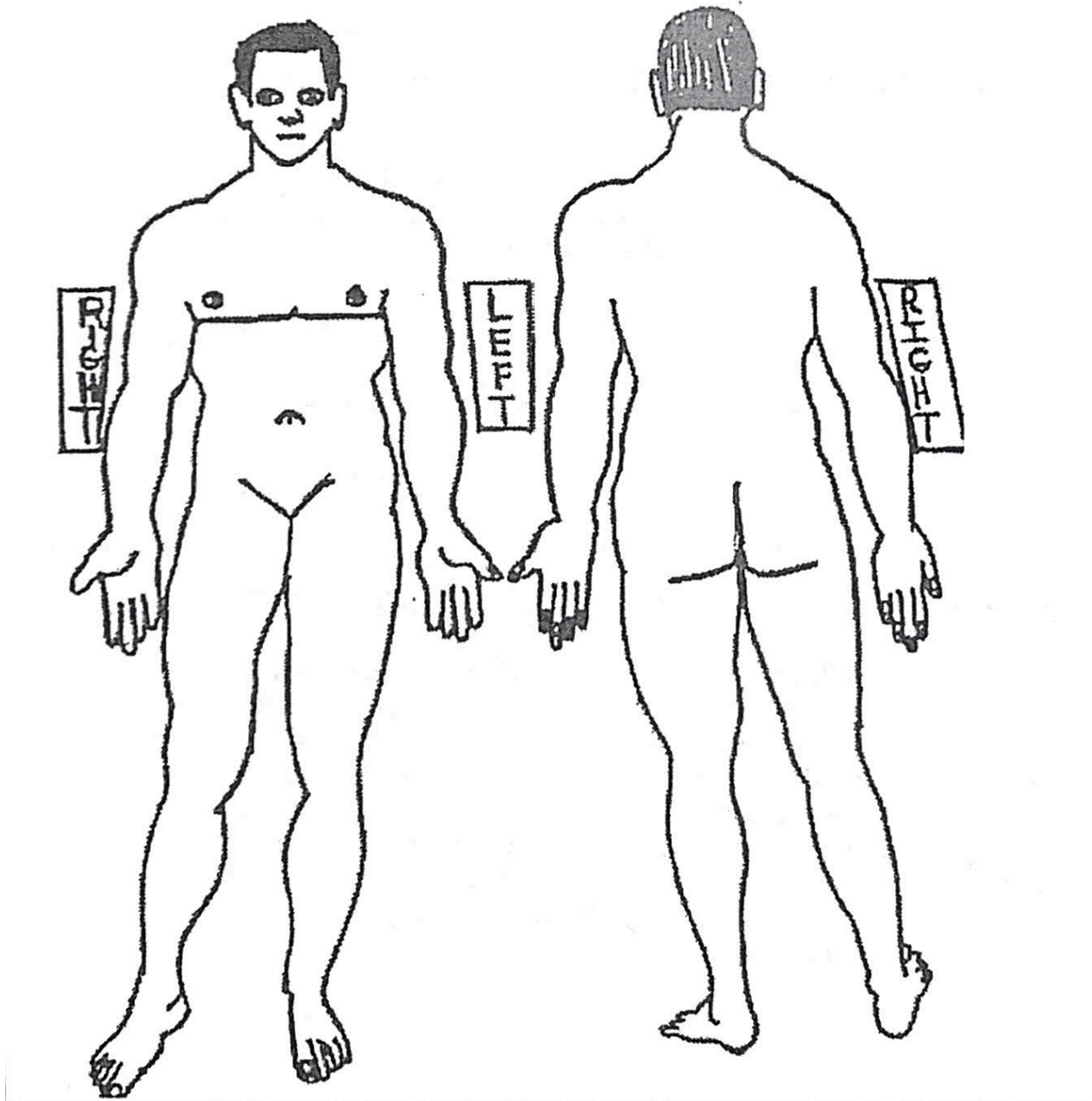
Last worked? _____

Is there any worker's compensation or litigation related to your condition? yes no
(Please circle one or both and explain)

If you have had previous spine surgery, please describe:

- | Date | Surgeon | Procedure |
|------|---------|-----------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |

On the diagram below, please mark where you have pain/numbness/tingling:



SOCIAL HISTORY:

Marital status: Married Single Divorced Separated Widowed

Children _____ Ages of Children _____

Do you Smoke? yes no. If yes, how many packs per day _____, how many years in the past? _____

Do you use other tobacco products? yes no Cigars Chewing Tobacco Snuff vape

Do you drink alcoholic beverages? yes no. If yes, how much, how often: _____

CURRENT MEDICATIONS (name of drug and dosage)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Are you allergic to any medications? If yes, please list medications and reaction:

If female, is there any possibility you could be pregnant? Are you on contraception? yes no

LMP Date: _____

LIST OF ALL SURGERIES THAT YOU HAVE HAD:

SURGERY	DATE	SURGERY	DATE
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1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

PAST MEDICAL HISTORY: Conditions for which you have had or are currently receiving treatment:

Hypertension

Heart Disease

Arrhythmia

Chest Pain

High cholesterol

Heart attack

Stroke

Blood clots

Diabetes

Tuberculosis

Positive HIV or AIDS

Breast cancer

Colon cancer

Other cancer

Peptic ulcer

Hepatitis or jaundice

Liver/Pancreas disease

Sexually transmitted diseases

Emphysema

Other

Gastric reflux

Anemia

Arthritis

Kidney failure

Other Kidney disease

Seizure disorder

Received blood transfusion

Asthma

Thyroid disease

FAMILY HISTORY: for blood relatives only: check if any relative had any of the following

	Living	High blood pressure	Heart Disease	Diabetes	Stroke	Bleeding problems	Cancer	Other Problems (describe)
FATHER	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandmother	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandfather	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOTHER	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandmother	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandfather	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother/Sister	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

REVIEW OF SYSTEMS:

Undesired Weight Loss	Swelling of Ankles	Diarrhea
Weight Gain	Headaches	Constipation
Heartburn	Abnormal Bleeding	Difficulty Swallowing
Burning on Urination	Fevers	Nausea
Poor Appetite	Chills	Vomiting
Cough	Sweats	

1. Circle all that describe your pain: (sharp, dull, stabbing, aching, burning, shooting, numbing, constant, tingling, pins/needles, stiffness, throbbing, stinging, pulling, gnawing, cramping, pinching, pressing)
2. What activities or body positions make your pain worse?
3. What body positions or activities decrease your pain?
4. Is your pain worse at night? Yes or No

DRAW AN X ON THE LINE THAT BEST DESCRIBES YOUR PAIN:

