NEW PATIENT QUESTIONNAIRE

Name_____ Birthdate _____/_____/____ Sex_____

Address_____(Apt #____) City_____ State_____ Zip_____

Home phone (____)_____ Cell phone (____)_____

Social Security# _____-____-_____ Driver license #_____ State_____

E-Mail:_____ Preferred contact: ☐ home, ☐cell, ☐work, ☐email

Employer_____ Occupation_____

Work address_____City_____ State_____ Zip_____

Work phone (____)_____ Years employed_____

Marital status ❒ Single ❒ Married ❒ Other Preferred Language _____

Ethnicity: ☐ Native American ☐Asian ☐ African/American ☐ Hispanic/Latino
☐White ☐ Pacific Islander ☐ Mexican/American ☐ Decline to state

Current Height:_____ Current Weight:_____

Spouses name_____ Spouses employer _____

Nearest relative (not living with you)_____ Relationship_____

Address_____ Phone (___) _____

Family physician_____ Phone (___)_____

Emergency contact_____ Phone(___)_____

Who is financially responsible for this bill_____

Insurance information: ❒ Medicare ❒ Group ❒ Worker's Comp ❒ Auto ❒ None

Primary insurance:_____ Policy #_____

Address_____ Group #_____

City_____ State_____ Zip_____ Phone ( )_____

Name of insured_____ Relationship to insured_____

Secondary insurance _____ Policy #__

Address_____ Group #_____

City_____ State_____ Zip_____ Phone ( )_____

Name of insured_____ Relationship to insured_____

PRESENT COMPLAINTS

Please describe the health problem for which you came to our office_____

_____

Please describe the character of your current pain: ❒ Sharp/stabbing ❒ Dull ❒ Aches ❒ Soreness ❒ Weakness ❒ Throbbing ❒ Numbness ❒ Cramping ❒ Burning

How often are the complaints present? ❒ Constant (76-100%) ❒ Frequent (51-75%) ❒ Occasional (26-51%) ❒ Intermittent (25% or less)

How bad is your level of pain? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

Since your problem began is the pain: ❒ Increasing ❒ Decreasing ❒ Not Changing

When did your problem begin? Specific date if possible:_____

Did your problem begin: ❒ After a specific incident ❒ Multiple incidents ❒ Gradually

Describe how your problem began_____

_____

How many times have you had a problem similar to or the same as this in the past?
❒ None previously ❒ 6-10 episodes ❒ Single continuous episode
❒ 1-5 episodes ❒ more than 10 episodes

When was the very first time you ever felt something similar to or the same as this problem?
❒ Less than 6 months ago ❒ 1-5 years ago ❒ 10-20 years ago
❒ 6 months- 1 year ago ❒ 5-10 years ago ❒ more than 20 years ago

What treatment have you received for the present condition? ❒ Surgery ❒ Spinal injections ❒ Physical therapy ❒ Medication ❒Other_____ ❒ None

What makes your problem better?❒ Nothing ❒ Laying down ❒ Walking ❒Standing ❒ Sitting ❒ Movement/Exercise ❒ Inactivity ❒ Other_____

What makes your problem worse?❒ Nothing ❒ Laying down ❒ Walking ❒Standing ❒ Sitting ❒ Movement/Exercise ❒ Inactivity ❒ Other_____

Are your symptoms the result of an auto accident, work injury or other personal injury?_____

If you answered yes, please fill out an accident specific form available at the desk.

MEDICAL HISTORY

Are you now or have you suffered from the following?

Past	Present		Past	Present	
❒	❒	Asthma	❒	❒	Neck pain
❒	❒	Arthritis	❒	❒	Shoulder pain
❒	❒	Cancer	❒	❒	Upper back pain
❒	❒	Diabetes	❒	❒	Arm/Hand pain
❒	❒	Dizziness/Fainting	❒	❒	Low back pain
❒	❒	Headaches	❒	❒	Hip pain
❒	❒	Heart attack/disease	❒	❒	Knee pain
❒	❒	High blood pressure	❒	❒	Foot/ ankle pain
❒	❒	Migraines	❒	❒	Stroke
❒	❒	Emphysema	❒	❒	Ulcers
❒	❒	Thyroid problems	❒	❒	Kidney or Urinary problems
❒	❒	Digestive disorders	❒	❒	Prostate problems
❒	❒	Anorexia	❒	❒	Heartburn/ indigestion
❒	❒	Hepatitis	❒	❒	Drug or alcohol dependence

WOMEN ONLY:

Are you pregnant or think you may be pregnant?_____

Date of last menstrual period_____

Do you have any condition, disease or problem not listed above?_____

Do you smoke or use any tobacco products?_____ If yes, how much_____

Former smoker: Quit how long ago_____ How much smoked_____

Do you drink alcoholic beverages?_____If yes, how often _____

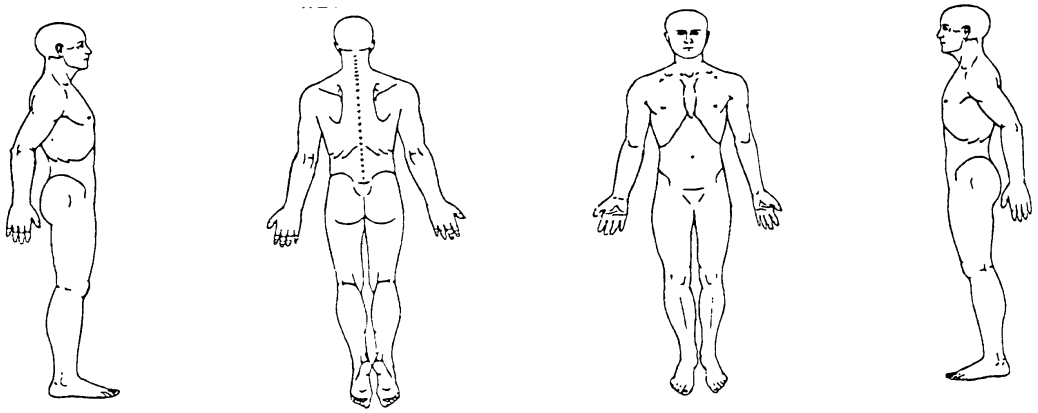
Have you had any other serious illness/ trauma (falls, accidents), surgeries or been hospitalized?____

_____

Please list all medications including birth control pills, aspirin, or vitamins that you are presently taking

_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



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