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PATIENT QUESTIONNAIRE

Patient Name:		Date:
Age:	Birth Date:	Are you ☐ Right or ☐ Left handed?
Occupation:		Employer:
Primary Physician:		Who referred you to our office?

CHIEF COMPLAINT

Why are you seeing the Doctor Today?

Current problem is a result of a(n): ☐ Car Accident ☐ Work Accident ☐ Injury ☐ Other

HISTORY

Date symptoms started or date injury occurred:

Area of body involved (☐ Right - ☐ Left):

Describe the problem:

When does the problem occur?

How often does this occur?

How long does it last?

What makes the problem better?

What makes the problem worse?

Circle your level of pain: None - Mild - Moderate - Severe - Unbearable

What do you think is the cause of your problem?

ASSOCIATED SYMPTOMS (check all that apply)

☐ pain	☐ weakness	☐ pain worse at night
☐ swelling	☐ tingling	☐ problem is constant
☐ limited motion	☐ numbness	☐ problem is intermittent
☐ locking or catching	☐ fever/chills	☐ problem is activity related
☐ giving out	☐ redness	

TREATMENTS AND TESTING

What medications have you tried for this problem?

Physical Therapy? (☐ Yes - ☐ No) When? Where?

X-rays? (☐ Yes - ☐ No) When? Where?

MRI ? (☐ Yes - ☐ No) When? Where?

List any other treatments or testing done for this problem:

PAST & CURRENT MEDICAL PROBLEMS

Surgeries - Hospitalizations	Year	Complications

Have you ever had general anesthesia? ☐ No ☐ Yes
Any problems with anesthesia? ☐ No ☐ Yes Describe:

LIST YOUR **MEDICATIONS** AND DOSES

☐ Check here if instead of hand writing your medications you are submitting a legible copy of your med list

ALLERGIES – below list all your MEDICATION ALLERGIES & describe your reaction

☐ No known medication allergies ☐ Iodine Allergy ☐ Latex Allergy ☐ Adhesive Tape Allergy

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live with Partner
Children? ☐ No ☐ Yes #__________________ How many people live in the home?________________
Do you drive? ☐ Yes ☐ No If no, who drives for you ?____________________________________
Do you have to climb stairs to get to your bedroom? ☐ Yes ☐ No Your bathroom? ☐ Yes ☐ No
Do you Exercise? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
What type of exercise?____
Hobbies:____
Smoke currently? ☐ No ☐ Yes _________ Packs per day for _________ years.
Quit smoking? ☐ This year ☐ > 1 year ago ☐ > 5 years ago ☐ > 10 years ago
How much alcohol do you drink? ☐ None ☐ Rarely or # of Drinks____ ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month

FAMILY HISTORY

Do any medical problems run in your family? ☐ No ☐ Yes Describe:

Any Family history of Arthritis or Joint problems? ☐ No ☐ Yes Describe:

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

	No	Yes	Describe all Yes Responses unless already described on previous pages
High Blood Pressure	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Heart Disease	☐ No	☐ Yes	
Chest Pain	☐ No	☐ Yes	
Cancer	☐ No	☐ Yes	
Lungs, Breathing	☐ No	☐ Yes	
Digestion or Ulcers	☐ No	☐ Yes	
Blood Clots	☐ No	☐ Yes	
Bleeding problems	☐ No	☐ Yes	
Vision	☐ No	☐ Yes	
Hearing loss	☐ No	☐ Yes	
Swallowing	☐ No	☐ Yes	
Bowels	☐ No	☐ Yes	
Bladder - Urination	☐ No	☐ Yes	
Balance problems	☐ No	☐ Yes	
Numbness/tingling	☐ No	☐ Yes	
Blackout/fainting	☐ No	☐ Yes	
Depression or Anxiety	☐ No	☐ Yes	
Psychiatric problem	☐ No	☐ Yes	
Hepatitis	☐ No	☐ Yes	
HIV/AIDS	☐ No	☐ Yes	
Arthritis	☐ No	☐ Yes	
MRSA Infection	☐ No	☐ Yes	

Patient Signature:______________________________ **Date:**________________

Reviewed By:______________________________ **Date:**________________