



New Patient Questionnaire

Patient name: _____

Date completed: _____

Date of Birth: _____

Age: _____

Date of Injury: _____

Do you have any allergies or medication reactions? Yes No

If yes, please describe:

What are you being seen for today?

Describe how your injury/problems happened:

Describe any other serious injuries/problems:

Have you had any of the following studies done related to your injury? (check all that apply):

- X-Ray MRI Nerve studies CT Scan Ultrasound Recent bloodwork

Have you had any of the following treatments related to your injury? (check all that apply):

- Surgery Physical Therapy Pain counseling Injections Acupuncture Yoga
 Chiropractic Medications

Activities of Daily Living: Put an X in the appropriate boxes

Activities	Able to do without pain	Able to do with pain	Unable to do
Self-Care			
Dressing			
Combing hair			
Bathing/Showering			
Getting on and off the toilet			
Brushing teeth			
Eating			
Cooking			
Communication			
Seeing			
Hearing			
Speaking			
Physical Activity			
Sitting			
Standing			
Walking on uneven ground			
Climbing stairs			
Light housework			
Heavy housework			
Sensory			
Feeling			
Smelling			
Tasting			
Hand Activities			
Writing			
Typing			
Opening doors			
Opening jars			
Turning faucets on and off			
Folding laundry			
Travel			
Getting in and out of a car			
Driving			
Flying			

How long are you able to walk at a time? 30 mins 1 hour 2 hours 3 hours 4+ hours other: ____

How long are you able to sit at a time? 30 mins 1 hour 2 hours 3 hours 4+ hours other: ____

How long are you able to stand at a time? 30 mins 1 hour 2 hours 3 hours 4+ hours other: ____

How many pounds are you able to carry? Up to 10lb Up to 20lb Up to 30lb Up to 40lb 50lb+ other::__

How many pounds are you able to lift? Up to 10lb Up to 20lb Up to 30lb Up to 40lb 50lb+ other:__

Describe your symptoms: (please circle for each body part)

Body Part: _____

Frequency

- All of the time
- Most of the time
- Comes and goes
- Not often

Quality

- Aching
- Burning
- Stabbing
- Pins and Needles

Additional Comments

Body Part: _____

Frequency

- All of the time
- Most of the time
- Comes and goes
- Not often

Quality

- Aching
- Burning
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- Pins and Needles

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Body Part: _____

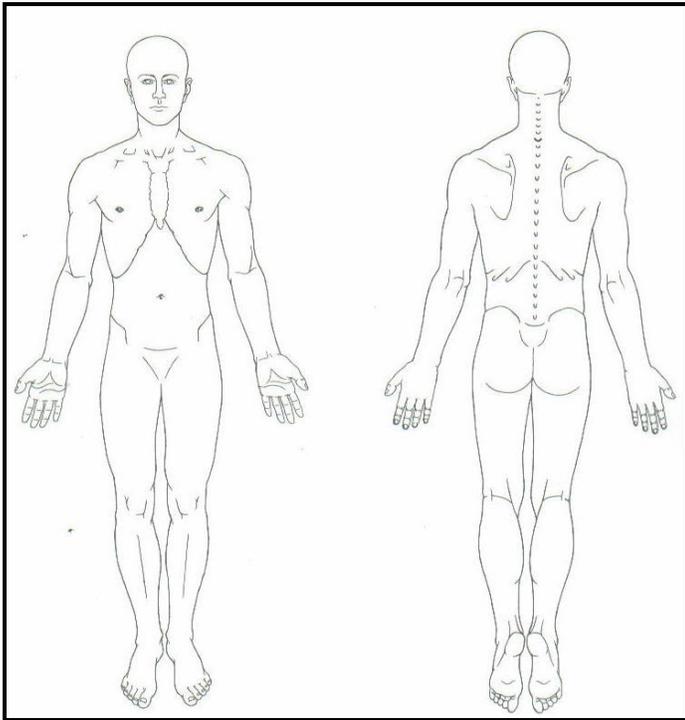
Frequency

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Mark an X on the spots that you have pain:



Please circle a number from the scales below:

At its best, how would you rate your overall pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

At its worst, how would you rate your overall pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Today, how would you rate your overall pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Surgeries (Check all that apply):

- Neck Spine Leg Foot
- Knee Arm Hand
- Other: _____

Personal and Family Medical Conditions:

	<u>You</u>	<u>Family</u>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/liver disease	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent fevers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

For women:

Are you currently pregnant? Yes No

Personal History

Which hand do you write with? Right Left

Social History:

Are you: Single Married Separated Divorced Widow(er)

Do you have children? Yes No If Yes, please list ages: _____

Who do you live with? (Check all that apply)

Alone Spouse Children Parents Roommates Other: _____

Circle the highest level of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 G.E.D

College (Some Associates Degree Bachelor's Degree) Graduate School Trade School

How often do you exercise? never rarely occasionally regularly

Please List any current Hobbies/Sports: _____

Alcohol: Current Former Never **If current:** regularly occasionally rarely
Cigarettes/Tobacco: Current Former Never **If current:** regularly occasionally rarely
Medicinal Marijuana: Current Former Never **If current:** regularly occasionally rarely
Recreational drugs: Current Former Never **If current:** regularly occasionally rarely

Vocational Status:

Company and Job title at time of the Injury: _____

Are you currently employed? Yes No If no: Laid-off Quit Retired Terminated

If yes, what is the name of the current company and job title? _____

Full Time Part Time

Disability Status:

Are you currently receiving workers' compensation disability benefits? Yes No
If yes, check the appropriate box: Temporary disability benefits Permanent disability benefits

Have you been determined to be permanent and stationary? Yes No Don't know
If yes, what is the date and the physician's name who declared you permanent and stationary?
_____/_____/____ (date) _____ (physician's name)

Are you currently receiving Social Security benefits? Yes No
Are you currently receiving long term disability benefits? Yes No
Are you currently receiving State Disability benefits? Yes No
Are you currently receiving unemployment benefits? Yes No

Current Medications (include all prescribed and over the counter, including supplements):

Name	Strength	Dosage (example 2x day)	Average number taken weekly

Review of Systems: (check all that apply)

General

- Change in appetite
- Fever
- Extreme daytime sleepiness
- Poor sleep
- Weight changes
- Irritability
- Sexual problems
- Fatigue (feeling tired)
- Night sweats
- Physical/Emotional abuse

Cardiovascular

- Chest pain
- Irregular heartbeat
- Edema (leg swelling)
- High Blood Pressure
- Murmur

Endocrine

- Extreme hunger
- Extreme sweating
- Extreme thirst
- Unusual hair loss
- Cold intolerance
- Heat intolerance
- Thyroid Problems

Gastrointestinal

- Abdominal pain
- Bloating
- Blood in stool
- Change in bowel habits
- Constipation
- Diarrhea
- Fecal incontinence
- Food intolerance
- Gallstones

- Heartburn
- Hemorrhoids
- Liver problems
- Indigestion
- Jaundice
- Laxative use
- Nausea
- Vomiting
- Vomiting blood

Head

- Deformity
- Dental Problems
- Head injury
- Headache
- Nosebleeds
- Sinus problems
- Trouble swallowing
- Visual changes

Musculoskeletal

- Arthritis
- Muscle wasting
- Crepitation
- Bone deformity
- Gout
- Limitation of motion
- Muscle cramp
- Back pain
- Bone pain
- Joint pain
- Muscle pain
- Stiffness

Neck

- Enlarged Thyroid
- Neck mass
- Neck pain

- Stiffness
- Swollen glands

Neurological

- Abnormal Gait
- Blackouts
- Clumsiness
- Concentration problems
- Confusion
- Dizziness
- Fainting
- Focal weakness
- Increased sensation
- Decreased sensation
- Incoordination
- Involuntary movement
- Numbness
- Paralysis
- Seizures
- Tingling
- Tremors
- Weakness

Peripheral Vascular

- Blood clots
- Cold feet
- Cold hands
- Cramps
- Varicose veins

Psychiatric

- Anxiety
- Depression
- Hallucinations
- Insomnia
- Irritability
- Mood swings
- Panic episodes

