Be Well PRIMARY HEALTH CARE CENTER

DIAGNOSTIC AND TREATMENT CENTER
NYS Article 28 Facility
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Questionnaire:

1. What is the reason for today's visit?

_____

2. Did you have this problem in the past? If yes, please describe when and who was physician treating it?

_____

_____

3. Is this visit related to Worker's Compensation case/injury?
☐ YES ☐ NO

4. Is this visit related to No-Fault/car accident case/injury?
☐ YES ☐ NO

5. Did you have X-rays, MRIs or CT-Scans done? ☐ YES ☐ NO

If yes, do you have the films and reports available? ☐ YES ☐ NO

6. Are you taking any pain medications? ☐ YES ☐ NO

If yes, what kind?_____

7. Do you need translator services? ☐ Yes ☐ No

If yes, in what language? _____

Date:_____ Signature: _____