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NAME:_____ DOB:_____ DATE:_____

PATIENT QUESTIONNAIRE

CHIEF COMPLAINT: (Check all that apply): ☐ Headache ☐ Neck pain ☐ Shoulder/arm pain ☐ Other
☐ Low back pain ☐ Buttock pain ☐ Leg pain

(Describe): List in order of severity:

1) _____ 3) _____
2) _____ 4) _____

Is your overall problem: ☐ Getting better ☐ Getting worse ☐ Staying the same

How did your pain begin: ☐ Unknown ☐ Auto accident ☐ Trauma ☐ Other cause
(Describe)_____

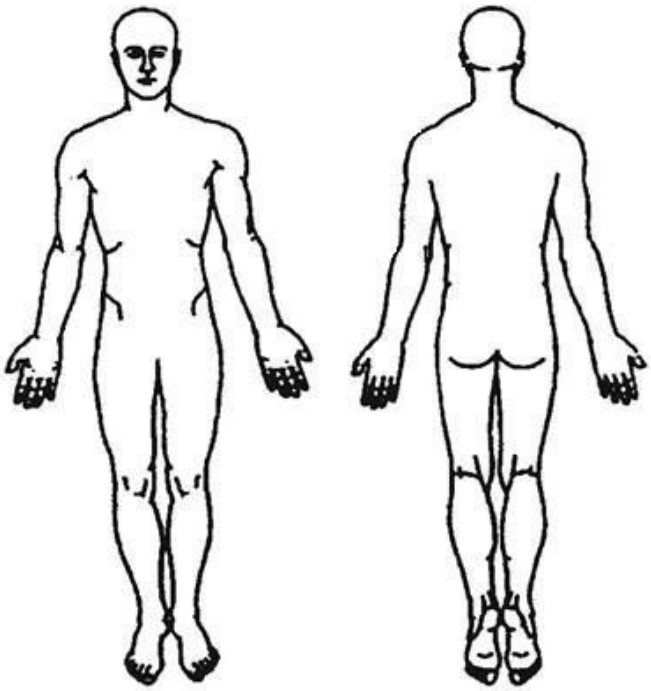
_____

Current Height:_____ Current Weight: _____

When did your pain begin? Date:_____

Where is your pain?
Click on the diagrams below and type the following symbol(s) to describe the location and character of pain:

BURNING: XXXXX ACHING: VVVVV STABBING: ///// PINS & NEEDLES: . . . . . NUMBNESS: NNNNN



NAME: _____ DOB: _____ DATE: _____

What is the current diagnosis: Check all that apply

Headache/neck pain: ☐ Cervical strain ☐ Migraine ☐ Herniated disc ☐ Thoracic pain ☐ No diagnosis

Back pain: ☐ Lumbar strain ☐ Herniated disc ☐ Sciatica ☐ Sacroiliac problem ☐ No diagnosis

Joint: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ No diagnosis

Other: _____

What makes your pain better? _____

What makes your pain worse? _____

Is your pain worse on the: ☐ LEFT ☐ RIGHT ☐ BOTH

PREVIOUS TREATMENT

Physical therapy: ☐ YES ☐ NO Length of treatment: _____

Did this help: ☐ YES ☐ NO Where: _____

Chiropractic: ☐ YES ☐ NO Length of treatment: _____

Did this help: ☐ YES ☐ NO Where: _____

Massage: ☐ YES ☐ NO Length of treatment: _____

Did this help: ☐ YES ☐ NO Where: _____

Injection: ☐ YES ☐ NO Length of treatment: _____

Did this help: ☐ YES ☐ NO Where: _____

Other treatment: ☐ YES ☐ NO Length of treatment: _____

Describe the treatment: _____

Did this help: ☐ YES ☐ NO Where: _____

List the previous medical doctors you have seen for your condition/pain:

MD: _____ MD: _____ MD: _____

Injury: _____ Injury: _____ Injury: _____

IMAGING STUDIES PERFORMED:

			DATE	**WHERE**
Plain x-rays	☐ YES	☐ NO	_____	_____
CT scan	☐ YES	☐ NO	_____	_____
MRI scan	☐ YES	☐ NO	_____	_____
Myelogram	☐ YES	☐ NO	_____	_____
Discogram	☐ YES	☐ NO	_____	_____
Other	☐ YES	☐ NO	_____	_____

If other treatment, please describe: _____

***IF YOUR PROBLEM WAS CAUSED BY A WORK INJURY, COMPLETE SECTION C.**

***IF YOUR PROBLEM WAS CAUSED BY AN AUTO ACCIDENT, COMPLETE SECTION D.**

NAME: _____ DOB: _____ DATE: _____

SECTION C: (WORK INJURY)

Date and time of injury: _____

Describe your injury in detail: _____

_____

Did you file an incident report: ☐ YES ☐ NO

Any history of previous symptoms or injuries: ☐ YES ☐ NO

If yes, please explain: _____

Any history of previous missed work due to injury: ☐ YES ☐ NO Are you working now: ☐ YES ☐ NO

When was the last time you worked full time: _____ Part time: _____

Do you have any current work restrictions: ☐ YES ☐ NO

If yes, please explain: _____

Detail your job description: _____

Do you have a lawyer working on this claim: ☐ YES ☐ NO

If yes, name and contact information for lawyer: _____

SECTION D: (AUTO ACCIDENT INJURY)

Are you working now: ☐ YES ☐ NO

When was the last time you worked full time: _____ Part Time: _____

Total time lost from work: _____

Do you have any current work restrictions: ☐ YES ☐ NO

If yes, please explain: _____

Date, time, and location of accident: _____

Make and model of car: _____ Amount of damage _____

Other passengers injured in your car: _____

Your position in the car: _____ Seat belt worn: ☐ YES ☐ NO

How accident occurred: _____

Did you lose consciousness: ☐ YES ☐ NO

Initial treatment at: _____

Transported by: ☐ Ambulance ☐ Private vehicle

Type of treatment: _____

Location and type of pain: _____

Do you have a lawyer working on this claim: ☐ YES ☐ NO

If yes, name and contact information for lawyer: _____