

Physical activity Better Worse No change Don't know
 Heat Cold Better Worse No change Don't know
 Massage Better Worse No change Don't know

Patient Intake Questionnaire 2 of 3

Name _____ **DOB:** ____/____/____ **Date** ____/____/____

IF YOU HAVE HAD ANY DIAGNOSTING TESTING DONE PLEASE BRING IMAGES AND REPORTS :

	DATE	LOCATION
Bone Scan	____/____/____	_____
CT Scan	____/____/____	_____
Myelogram	____/____/____	_____
EMG	____/____/____	_____
X-Rays	____/____/____	_____
Blood Work	____/____/____	_____
Discogram	____/____/____	_____
MRI	____/____/____	_____

What kind of treatment have you received in this current episode of pain?

Physical Therapy Yes____ No____ **DATES: FROM:** _____ **TO:** _____
Chiropractor Yes____ No____ **DATES: FROM:** _____ **TO:** _____
 Bed Rest Yes____ No____ Medication Yes____ No____ Brace Yes____ No____
 Facet Injections Yes____ No____ Epidural Injections Yes____ No____ Acupuncture Yes____ No____
 Other Injections Yes____ No____ Other: _____
Spine Surgery Yes____ No____ **Type:** _____

If yes, (When/Where/by Whom) _____

What medications (ALL) are you currently taking (dose) including pain medication/anti-inflammatory etc.?

Medication Allergies/Reactions _____

Have you had any previous complications with anesthetics? No _____ Yes _____
 Have you had problems with addiction to prescription or non-prescription medications? No _____ Yes _____

Past **MEDICAL/SURGICAL** history (please include When/Where/by Whom):

Family Medical History: _____

Do you exercise regularly? Yes _____ No _____
 What activities do you do?

Strengthening: _____

Bike: _____

Running: _____

Stretching: _____

Walking: _____

Other: _____

Patient Intake Questionnaire 3 of 3

Name _____ DOB: ____/____/____ Date ____/____/____

Check all symptoms you now have:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Shortness of breathe |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Reflux | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Heart skipping | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Gerd | <input type="checkbox"/> Bloody sputum |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Throat disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Constipation | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Change in bowl habits | <input type="checkbox"/> Trouble swallowing |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Significant weight change | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Anxiety/disorders |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Decreased range of motion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Menstrual changes | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Numbness | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Renal disorder | <input type="checkbox"/> Muscle weakness/paralysis | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Tremor dizziness | |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Oral lesions |
| <input type="checkbox"/> Eye pain/redness | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Skin lesions |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Persistent infections | <input type="checkbox"/> Skin sores |
| <input type="checkbox"/> Hearing loss | | <input type="checkbox"/> Rash/bumps |
| <input type="checkbox"/> Nose bleeds | | |

What is your height: _____ Weight: _____

Relationship Status: Married Single Divorced Widowed Children, if so how many? _____

Smoking Status: never smoker Years smoked _____
 current every day smoker Packs per day: <=0.5
 current some day smoker 1.0
 former smoker 1.5
 smoker current status unknown 2.0
 unknown, if ever smoked >2.0

Do you Drink Alcohol? Yes _____ No _____ **# of Drink(s) per week?** _____

What is your current occupation/work status? _____

Are you involved in a personal injury lawsuit because of your pain? Yes _____ No _____

If so: Are you currently working? Yes _____ No _____ How long have you been out of work: _____

Is this a work related injury? Yes /No **EMPLOYER:** _____ **PHONE:** _____

If so: Are you currently working ? Yes _____ NO _____ How long have you been out of work: _____

Are you receiving Workers Compensation Benefits? Yes _____ No _____