NEW PATIENT QUESTIONAIRE

GENERAL INFORMATION:

Name _____ Male Female Date _____
(circle one)
Address _____ Home phone_____
City _____ State _____ Zip code _____ Cell phone _____
Date of Birth _____Social Security# _____ Work phone _____
Employer _____ Occupation _____
Address _____ City _____ State _____ Zip code _____

DESCRIPTION OF INJURY:

1. What is the date of your injury? _____
2. Is your injury the result of an: auto accident work injury other
(circle one)
If other, please explain._____
_____
_____
3. Have you seen a chiropractor, medical doctor or physical therapist outside of this office for you injury? _____ If yes, whom did you see? _____
4. Using the diagram below, please mark the areas of your pain.
5. Describe the character of your symptoms: (circle ones that apply)
burning tingling numbness dull stabbing shooting radiating
6. Since your symptoms began have they: improved worsened stayed the same?
(circle one)
7. Are your symptoms: constant intermittent?
(circle one)
8. List anything that you have tried to relieve you symptoms, please explain.
_____
_____
9. What aggravates your symptoms? _____
_____
10. Is your sleep disturbed by these symptoms? Yes No
(circle one)
11. Are you restricted/limited in any work, home, or recreational activities because of your injury? Yes No If yes, please explain. _____
_____
_____

Medical/Social History

1. Have you or any of your family members suffered from any of the following conditions?
(Answer Y or N)

ALLERGIES _____ EPILEPSY _____
ALCOHOL DEPENDENCE _____ FATIGUE _____
ANEIMA _____ HEART ATTACK/DISEASE_____
ARTERIOSCLEROSIS _____ HIGH BLOOD PRESSURE_____
ARTHRITIS _____ HIV INFECTION _____
BACK SURGERY _____ KIDNEY DISEASE _____

BROKEN BONES _____ LOW BLOOD PRESSURE _____
CANCER _____ MIGRAINES _____
DEPRESSION _____ MOTION SICKNESS _____
DIABETES _____ MULTIPLE SCLEROSIS _____
DIZZINESS/FAINTING _____ POLIO _____
DOUBLE OR BLURRED VISION _____ RHEUMATIC FEVER _____
DRUG DEPENDENCE _____ STROKE _____
EAR INFECTIONS _____ TMJ _____
Please explain, if necessary. _____
_____
2. If you have any condition/disease not listed above, please explain. _____
_____
_____
3. Do you smoke? Yes No If yes, how often?_____
(circle one)
4. Do you drink alcohol? Yes No If yes, how often? _____
(circle one)
5. Do you drink caffeinated beverages? Yes No If yes, how often?_____
(circle one)
6. Please list all medications that you are presently taking. _____
_____
****
WOMEN ONLY:
1. Are you pregnant or think you may be pregnant ? _____
2. Please list the date of your last menstrual period. _____
3. Do you or have you suffered from any menstrual disorders? _____
If yes, please explain: _____
_____
_____
****
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

_____ _____
DATE PATIENT'S SIGNATURE