INITIAL QUESTIONNAIRE AND MEDICAL HISTORY

Name:

Age:

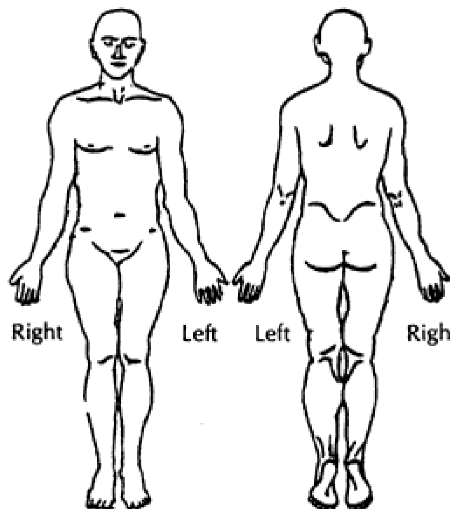
Date:

What is the reason for your visit today?	
Date of injury/onset of symptoms:	**Date of surgery (if applicable):**
Where did your injury occur?	Work Auto Home NA-Gradual onset Other:

Which best describes how your injury occurred?

Cumulative trauma/overuse	MVA
Degenerative process	Sports/Recreation
Fall	Trauma
Lifting	Unknown/Gradual onset

Shade areas of pain or discomfort on the figure below



Since onset, are your symptoms: (circle one)

Improving Worsening Not changing

Frequency of symptoms: (circle one)

Constant Intermittent/Daily Occasional

Nature of symptoms. Circle all that apply.

Burning	Sharp
Dull/Achy	Shooting
Numbness/Tingling	Throbbing

When is your pain the worst?

Morning Evening Neither

Please rate your pain on a scale of 0 to 10: At Present: ____ Lowest (last 24 hours):____ Highest (last 24 hours):____

0 = no pain 1, 2, 3 = low pain 4, 5, 6 = moderate pain 7, 8, 9 = intense pain 10 = emergency

What aggravates your symptoms? Circle all that apply.

Coughing/Sneezing	Lifting	Repetitive activities	Stress
Driving	Looking up overhead	Running	Sustained bending
Getting dressed	Reaching behind back	Sitting	Taking a deep breath
Going to/rising from sitting	Reaching out from body	Sleeping	Walking
Household activities	Reaching overhead	Stairs	
Kneeling/Squatting	Recreation/Sports	Standing	

Do your symptoms wake you up at night? NO YES. If yes, how often?

If yes, do you wake: While lying still Only when changing positions Both

What activities at home, work, or recreational are you unable to perform because of this injury/condition?

What relieves your symptoms? Circle all that apply.

Changing positions	Heat	Rest	Stretching
Cold	Massage	Sitting	Walking
Exercise	Medication	Splint/Brace wear	Nothing relieves my symptoms

Since the onset of your current symptoms, have you experienced any of the below? Circle all that apply.

Abdominal pain	Dizziness/Lightheadedness	Heart burn/Indigestion	Persistent cough
Bowel/Bladder changes	Fainting	Muscle weakness	Recent infection
Difficulty swallowing	Fever/Chills/Sweats	Nausea/Vomiting	Unexplained weight loss
Difficulty walking	Headaches	Night pain	Vision changes

Have you had any of the below tests for this condition? Circle all that apply.

X-ray	MRI	FCE/IME	Test results if known:
Arthrogram	CT scan	Other:	

Please indicate any previous or current treatment you have had related to your current injury. Circle all that apply.

Chiropractic/Osteopath	Massage Therapy	Occupational Therapy	Other:
Injection	Medication	Physical Therapy	None

PLEASE COMPLETE OTHER SIDE

Patient Name:___________________________________

WORK HISTORY				
Are you currently employed?	YES	NO	Retired	Student
Occupation:				
If injured on the job or work is affected by your current symptoms, please fill out next 3 questions.				
Are you currently working?	YES/Full Duty	YES/Light Duty	NO. Last day of full duty:	
Are you planning to return to your job of injury?	YES	NO	Unsure	
If no, has an alternate job goal been identified for you?	NO/I don't know YES, the new goal is:			

MEDICAL HISTORY				
At the present time, would you say that your health is:	Excellent	Good	Fair	Poor

Please indicate if you have had any prior injuries to the following joints. Circle all that apply.

Ankle | Back | Elbow | Foot | Hand | Hip | Knee | Neck | Shoulder

Please indicate if you have had or currently have any of the below medical conditions. Circle all that apply.

Allergies	Face/Ear/Jaw pain	Kidney disease	Pregnant (currently)
Anemia	Fibromyalgia	Latex or tape allergy	Rheumatoid arthritis
Asthma	Gout	Liver disease	Shortness of breath
Back/Neck pain	Heart disease	Migraines	Skin condition
Blood clots	Hepatitis	Multiple Sclerosis	Stroke /TIA
Cancer	Hernia	Osteoarthritis	Swelling in feet/legs
Chest pain	High blood pressure	Osteoporosis	Thyroid issues
Depression	HIV+/AIDs	Pacemaker	Tuberculosis
Diabetes	Imbalance	Parkinson's	
Epilepsy/Seizures	Incontinence	Polio	

Please list any other medical conditions we should know about:

Please list any surgeries you have had:

Have you had any major illnesses/hospitalizations in the last year? NO YES. If yes, please describe below.

MEDICATIONS: Please list all medications you are taking including dosage, frequency and route of administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability. If you have a list, please give it to our front office staff so that they may make a copy.

□ Please see attached list □ I am not taking any medications, vitamins or supplements

Name	Dosage	Frequency	Route of administration
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other

Have you had any falls in the past 12 months?	YES NO		
If yes, how many?		**Did you injure yourself in any of those falls?**	YES NO
Do you currently use any type of tobacco products?	YES NO		

_______________________________________ _______________________

Patient or Guardian Signature **Date**

For office use only: **Heart Rate:**__________ **Blood Pressure:**__________ **Taken by:**__________________________