PATIENT QUESTIONNAIRE

NAME: ________________________

GENDER: M / F

AGE: ____________

SMOKER: Y / N

PREGNANT: Y / N

OCCUPATION: ________________________________

SPORT ACTIVITIES/HOBBIES: __________________

DATE:_________________

What are we seeing you for?

Please Circle: LEFT / RIGHT

Neck, Shoulder, Elbow, Hand,
Mid Back, Low Back,
Hip, Knee, Ankle, Foot, Other.

PAST MEDICAL HISTORY: Please circle each condition that you currently have or have had in the past:

Fracture	Diabetes	Cancer	High Blood Pressure
Sprain/Strain	Osteoarthritis	Osteoporosis	Stroke
Trauma	Rheumatoid Arthritis	Heart Disease	Allergies/Asthma

Have you had a recent illness? (if yes, please explain):____

Do you take anti-inflammatory medication? Y/N

Do you take pain medication? Y / N

Other medications or supplements: ____

CURRENT MEDICAL HISTORY: Please circle each symptom that you are experiencing:

Numbness or Tingling	Poor balance (falls)	Nausea/Vomiting/Dizziness	Soreness/Ache
Increased pain at night	Shortness of breath	Difficult Walking/Running	Stiffness/Pain
Weakness	Headaches	Decreased Movement	

Other:____

What date (approximately) did your current pain start? ____

How did it start? (Gradually/ suddenly/from injury): ____

My symptoms are currently (circle one): Getting Better/ About the same/ Getting worse

What treatments have you received for this problem so far? _____________________________________

What makes your symptoms better? ____

What makes your symptoms worse? ____

Have you had an x-ray, MRI, or other imaging study for this problem? Y / N

On the scale below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

What are your personal goals for therapy at this time? ____

____