

**Patient Questionnaire**

Please do your best to answer completely.

Your name:	Date of Appointment:
Your date of birth:	Physician:
Age:	Are you: <input type="checkbox"/> Right handed <input type="checkbox"/> Male
Your phone #:	<input type="checkbox"/> Left handed <input type="checkbox"/> Female
<b>Emergency contact:</b>	

<b>**List your Allergies In This Box:</b>	<input type="checkbox"/> <i>Or check this box if you have no known allergies</i>
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Who **referred** you?  
(internist, family practitioner, etc)

Name: .....

Address: .....

City, ST ZIP: .....

Phone #: .....

Fax #: .....

What **pharmacy** do you use?

Name: .....

Address: .....

City, ST ZIP: .....

Phone #: .....

Fax #: .....

Check here if you do NOT want a report to be sent to your primary doctor or your referring doctor(s).

**What problem brings you to the doctor today?**

How long have you been bothered by this problem?

.....

.....

If you have pain, please rate your pain on a scale of 0 to 10 (0=No pain, 10=Worst possible pain): \_\_\_\_\_

**What other doctors have you seen, related to your current problem?**

.....

.....

**What tests have you had, related to your current problem?**

	when	where
<input type="checkbox"/> MRI scan (image of brain, neck, or back)	.....	.....
<input type="checkbox"/> CT scan (image of brain, neck, or back)	.....	.....
<input type="checkbox"/> EMG (electrical test of nerves and muscles)	.....	.....
<input type="checkbox"/> EEG (brain wave test)	.....	.....
<input type="checkbox"/>	.....	.....
<input type="checkbox"/>	.....	.....

## Social and Occupational Information:

### Living situation:

- assisted living
- house, condo, or apartment
- nursing care facility
- retirement/indep't living
- shelter
- other: \_\_\_\_\_

### Marital status:

- divorced
- married
- separated
- single
- widowed

### Who lives with you at home (check all that apply)?

- alone
- child(ren)
- friends
- grandchild(ren)
- parent(s)
- sibling(s)
- spouse

### Home Safety issues: check here if

- you have concerns about safety in your home
- you are (or have been) in an abusive relationship
- other: \_\_\_\_\_

### Tobacco:

- never smoked
- current smoker:  
Packs per day \_\_\_\_\_
- former smoker:  
Stop date: \_\_\_\_\_
- smokeless tobacco

### Alcohol:

- never used
- current user:  
Amount: \_\_\_\_\_
- former user:  
Stop date: \_\_\_\_\_

### Current or past drug use:

- never used
- current user:  
Type/How often? \_\_\_\_\_
- former user:  
Stop date: \_\_\_\_\_

### Check here if:

- you have tried unsuccessfully to quit smoking
- you have ever been told (or you know) you have a problem with alcohol
- you have ever been told (or you know) you have a problem with drug use (including prescription meds)

### Occupation:

- Current occupation: \_\_\_\_\_
- Retired date: \_\_\_\_\_
- Unemployed or laid off date: \_\_\_\_\_
- Disabled date: \_\_\_\_\_

### Check here if:

- You are involved in a lawsuit
- This visit is related to a disability
- This visit is related to a work injury
- This visit is related to an auto accident

Please provide details (including attorney address and any claim information) in this space, if applicable.

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Signature of patient

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Signature of person completing form  
(if not patient)

This form contains four pages. Please complete pages 3 and 4 as well.



## Review of Systems:

Please check all applicable.

### Constitutional

- | No                       | Yes                      |                                 |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fevers                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble <i>getting</i> to sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble <i>staying</i> asleep   |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight gain                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss                     |
| <input type="checkbox"/> | <input type="checkbox"/> |                                 |

### Eyes

- | No                       | Yes                      |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision  |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of vision |
| <input type="checkbox"/> | <input type="checkbox"/> |                |

### Ears, Nose, Mouth, and Throat

- | No                       | Yes                      |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sense of smell |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss           |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in your ears   |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |

### Cardiovascular and Respiratory

- | No                       | Yes                      |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations        |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> |                     |

### Gastrointestinal

- | No                       | Yes                      |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn    |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea       |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting     |
| <input type="checkbox"/> | <input type="checkbox"/> |              |

### Bladder & Sexual function (Genitourinary)

- | No                       | Yes                      |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control     |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of desire for sex      |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopause (women)           |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble with erection (men) |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgency to urinate          |
| <input type="checkbox"/> | <input type="checkbox"/> |                             |

### Skin

- | No                       | Yes                      |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Change in hair or nails |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in skin color    |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash                    |

### Neurological

- | No                       | Yes                      |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Falling down                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Incoordination                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Involuntary movements or jerking           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lightheaded or dizzy                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness/fainting/passing out |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure or convulsion                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinning or vertigo                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Swallowing problems                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremor                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble speaking                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble walking                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness                                   |
| <input type="checkbox"/> | <input type="checkbox"/> |  |

### Musculoskeletal

- | No                       | Yes                      |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain              |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain or swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain or cramps  |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain              |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |

### Endocrine

- | No                       | Yes                      |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heat or cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased thirst         |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of hair             |
| <input type="checkbox"/> | <input type="checkbox"/> |                          |

### Memory, Thinking, Mood, Psychiatric

- | No                       | Yes                      |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depressed mood                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Hallucinations (seeing or hearing things) |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory loss                               |
| <input type="checkbox"/> | <input type="checkbox"/> |   |

### Hematologic (blood) and lymphatic

- | No                       | Yes                      |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Slow to heal after cuts   |
| <input type="checkbox"/> | <input type="checkbox"/> |                           |

### Allergic and Immune

- | No                       | Yes                      |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic reaction to medicine or x-ray dye |
| <input type="checkbox"/> | <input type="checkbox"/> |  |

