

Patient Questionnaire

Name _____ Date _____
Age _____

Please answer the following questions to the best of your ability, it will help us to provide a more thorough evaluation.

What problem are you here for today?

How did the problem or injury occur?

Have you had any recent diagnostic testing done?

Yes No

X-ray MRI CT Other _____

Have you had treatment for this problem/injury before? Yes No

Are you experiencing pain as a result of your problem/injury? Yes No

Please list where you have pain in your body. Also, please mention if & where you have numbness or tingling:

Rate your pain:

0 being no pain 10 being worst pain

0 1 2 3 4 5 6 7 8 9 10

Past Medical History: Please check if you have had any of the following:

osteoarthritis	fibromyalgia
thyroid problems	lupus
osteoporosis	headaches
rheumatoid arthritis	broken bones
migraines	cardiac problems:
tuberculosis	diabetes
heart attack	pacemaker
angina	blood clots
stroke	high blood pressure
congestive heart failure	
multiple sclerosis	seizures
allergies	kidney disease
hepatitis	asthma
incontinence	chronic infections
cancer: list type _____	

depression painful periods
chemical dependency
of pregnancies: ____
prolonged steroid use pelvic pain
Other: _____

Medications: Please list any prescription and over the counter medications you are currently taking and the condition you are taking them for:

Surgeries: Please list any surgeries, major injuries or hospitalizations and the approximate date they occurred:

Do you use tobacco products (cigarettes, cigars, chew)

Yes No

If yes, how much do you use per day? _____

If yes, for how many years? _____

Do you consume alcoholic beverages?

Yes No

If yes, how much do you consume?

____ drinks per day week

Therapy Solutions

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SYSTEM REVIEW: Please check any symptoms you are experiencing or have recently experienced.

CONSTITUTIONAL SYMPTOMS

chills sweating fever
slow/rapid pulse fatigue
loss of appetite sleep disturbance
nausea/vomiting
unexplained weight changes

MUSCULOSKELETAL

joint swelling/pain muscle pain
weakness cold hands

NEUROLOGICAL

headaches muscle wasting
vision changes involuntary movements
sensation of spinning tremors
paresthesias radiating pain

CARDIOVASCULAR

chest pain palpitations
fainting leg cramps
difficulty breathing

PSYCHOLOGICAL

depression confusion
anxiety increased stress levels
irritability changes in appetite
changes in personal habits

HEMATOLOGICAL

skin color or nail changes
bleeding easily bruising

GASTROINTESTINAL

abdominal pain indigestion
difficulty swallowing bloody stools
diarrhea or constipation
change in bowel habits

ENDOCRINE

Hair/nail/skin changes loss of libido
temperature intolerance excessive thirst

PULMONARY

cough, hoarseness sputum
wheezing night sweats

GYNECOLOGIC

irregular periods painful periods
menopause vaginal discharge
spotting

GENITOURINARY

reduced urine stream
decreased urine output
incontinence impotence
painful intercourse
hesitation, urgency
frequent urination
painful urination

night time urination, more than once per night
burning, bleeding, change in urine color
testicular pain or swelling

What are your goals &/or expectations for therapy?

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