NEW PATIENT QUESTIONNAIRE

Name _____ __ Male __ Female Age ____

Height _____in. Weight _____lbs. Handed? Right / Left Are you pregnant? Y / N __ Not sure

What is your **primary complaint**?_____

When did it start? _____

How did it start? _____

Was it Sudden or Gradual? _____

Rate your pain on a scale of 1-10 with 1 being mild and 10 being the worst imaginable. ____/10

Describe the pain? __ Stiff __ Achy __ Sore __ Sharp __ Numb __ Tingling Other: _____

% of awake time you feel it? ____%

Is it worse at any time during the day or night? _____

What makes it better? _____

What makes it worse? _____

Does it radiate into your arms, hands, legs or feet? _____

Is your condition improving, staying the same or worsening? _____

Have you had this problem before? _____

Have you consulted another health care provider for this problem? Y / N _____

What was diagnosed and prescribed? _____

_____

Have you lost time from work? Y / N Unable to work from: ____/____/____ to ____/____/____

How does your pain affect you? __ Just deal with it. __ Trouble with daily activities __ Unable to accomplish certain tasks

Please indicate and explain any health issues other than mentioned above.

Eyes/Ears/Nose/Throat Y / N _____

Lungs/Sinus? Y / N _____

Heart? Y / N _____

Nerves? Y / N _____

Kidney? Y / N _____

Stomach Y / N _____

Musculoskeletal Y / N _____

Family history of disease? _____

_____

Current medications/supplements: _____

_____

Any prior injuries? _____

_____

Last chiropractic checkup? ____/____/____ Did you respond well? Y / N _____

Have you had spinal x-rays taken within the past year? Y / N Why? _____

I, the patient, do hereby certify that all information given is true, accurate, and complete.

Signature: _____ Date: _____

_____

_____