NEW PATIENT QUESTIONNAIRE

Name _____ __ Male __ Female Age ____

Height _____in. Weight _____lbs. Handed? Right / Left Are you pregnant? Y / N How far along? ____ wks

What is your **primary complaint**? _____

When did it start? _____

How did it start? _____

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

Is your pain __ Constant __ On and Off __ Dependent on Position Other _____

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

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

What activities hurt, you avoid or cannot do? _____

What lessens your pain? _____

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 seen another provider? Y / N What was diagnosed/prescribed? _____

_____

What other treatments have you had and did they help? _____

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

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 _____

Other: _____

Please list medications/supplements and reason you are taking them: _____

_____

Any prior injuries? _____

_____

Family history of disease: _____

_____

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

Have you had spinal x-rays taken within the past year? Y / N If yes, why? _____

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

Signature: _____ Date: _____