



NEW PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ yrs. Today's date: _____
 Primary Care Physician: _____ Referring Physician or Person: _____
 Occupation: _____ Are you Right-Handed or Left-Handed?
 Are you currently working? Yes No If no, what was the last day you worked: _____
 Do you have light duty restrictions? Yes No If yes, please list: _____
 Height: _____ ft. _____ in. Weight: _____ lbs.

History: Date symptoms started or injury occurred: _____ Was there an injury? Yes No
 Please describe your problem: Right Left Both

List any treatments or tests you have had for this problem:

Medications: _____ Injections: _____
 Physical Therapy: _____
 Has any of this treatment been helpful? _____
 Have you had an X-ray _____ MRI _____ Nerve Study _____
 What other specialists have you seen for this problem? _____

Rate your pain on a scale of 1 – 10? (1 = no pain, 10 = worst pain you have ever had) _____

Medical History:	Yes	No	When	Describe
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure				
Vascular/circulation problem				
Blood clot - leg or lung (DVT/PE)				
Arthritis (please indicate type)				
Stomach/intestine problem				
Cancer (please indicate type)				
Bleeding problem				
Clotting problem				
Nerve related problem (type)				
Breathing problem, asthma				
Kidney problem				
Thyroid problem				
Hepatitis or liver disease				
Depression/Psychiatric problem				
Severe sprains or dislocations				
Broken bones				
Other				

Is this a work-related problem? Yes No
If yes: Have you reported it to your employer as a worker's compensation claim? Yes No
 Employer: _____ How long have you worked there? _____

Please List the Following:
Current Medications

Past Surgeries

Year

Allergies

			<input type="checkbox"/> None
			Latex <input type="checkbox"/> Yes <input type="checkbox"/> No

Social History:

Single Married Divorced Separated Widowed Partner
 Do you live alone? Yes No
 Are you a caregiver for a family member at home? Yes No For whom? _____
 Do you smoke? No Yes # packs per day _____
 Do you drink alcohol? No Yes # drinks per day _____
 Do you use drugs? No Yes

Family History:

Family Member Age Alive? Deceased? List Illnesses or Cause of Death

Mother				
Father				
Brothers/Sisters	#: _____			
Children				

Review of Systems: (Circle all that Apply to You)

Gastrointestinal	ulcer colitis	hiatal hernia blood in stool	frequent indigestion
Urinary	kidney stones difficult burning	urination is: (circle all that apply) frequent bloody	painful
Neurological	paralysis tingling in arms or legs	weakness seizures	numbness tremor
Skin	chronic rashes infections or boils	itching	sores that don't heal
Vascular, Hematological, and Lymphatic	vein problems anemia easy bruising	phlebitis bleeding problems swollen node	clots calf pain when walking
Cardiac and Pulmonary	chest pain irregular heart beat	shortness of breath heart murmur	chronic cough wheezing
Endocrine	weight loss or gain	excessive sweating	
Musculoskeletal	swelling in multiple joints	excessive flexibility of joints	fibromyalgia

Reviewed by: _____ Date: _____