HEALTH QUESTIONNAIRE

Patient Name:______________________

MO		DAY	YR
1	7	1	95
2	8	2	96
3	9	3	97
4	10	4	98
5	11	5	99
6	12	6	00
	10	7	01
	20	8	02
	30	9	03
			04

DR#			PATIENT NUMBER									
0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬬. **Erase** changes cleanly. Do **not fold** this form.

A. PATIENT INFORMATION

Patient's Home Address

Phone **FAX**

Employer Business Address

Phone

Occupation

Social Security #

Referred By

Date Of Birth **Age**

Sex: ○ Male ○ Female

Marital Status:
○ Single
○ Married
○ Widowed
○ Divorced
○ Other

Patient Resides With:
○ Lives Alone ○ Spouse ○ Parents
○ Children ○ Other

Children:
○ Yes ○ No How Many? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

Spouse

Name

Social Security #

B: COMPLAINTS

1. What Are Your Primary Complaints? ○ ***None***

	LEFT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		RIGHT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S

2. What Are Your Secondary Complaints? ○ ***None***

	LEFT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		RIGHT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S
	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S

3. Additional Complaints? ○ Yes ○ No Please List:

4. When Did Your Symptoms Begin?
○ Date

5. How Often Do Your Symptoms Occur?
○ Occasional ○ Intermittent ○ Frequent
○ Constant ○ Other

6. How Would You Rate Your Pain Today With 0 Being No Pain and 10 Being The Worst Pain?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No Pain — Worst Pain Possible

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PLEASE MAKE NO MARKS IN THIS AREA

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