

CONFIDENTIAL PATIENT QUESTIONNAIRE

Name _____ Date of birth: ___/___/____ Today's Date: ___/___/201___

Dear Patient: In order for us to better help you, we need this important confidential questionnaire answered completely by you for your health care. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your health! Thank you.

Have you ever had Chiropractic Massage Physical Therapy care before? Yes No For what problem? _____
What type of care / treatment are you seeking from this clinic? Chiropractic Massage Therapy Physical Therapy Whatever Helps

What is your major complaint for which you came to our clinic? _____

Other complaints _____

Please describe in detail how your present illness developed / started from first sign and / or symptom to the present (includes time, place, reasons, courses, mode, results, etc.)

Are your symptoms the result of an auto accident, work- related injury or other personal injury(slip and fall, etc.)? If you answered yes, please fill out accident specific form, available at the front desk. Yes No

Did symptoms/pain begin gradually suddenly?
When was the very last episode of symptoms/discomforts experienced? _____
How long have you had these episodes of symptoms? _____

Please describe in detail how your health problem (s) disturbed / bothered you (including how each of the problems you described).

Are your symptom(s) / pain localized traveling? Please describe where your symptom(s)/pain go to:

Describe the quality / character of your symptom (s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

Since your symptoms began, have they improved worsened stayed the same?
What made your current symptoms worse? _____
What made your current symptoms better? _____

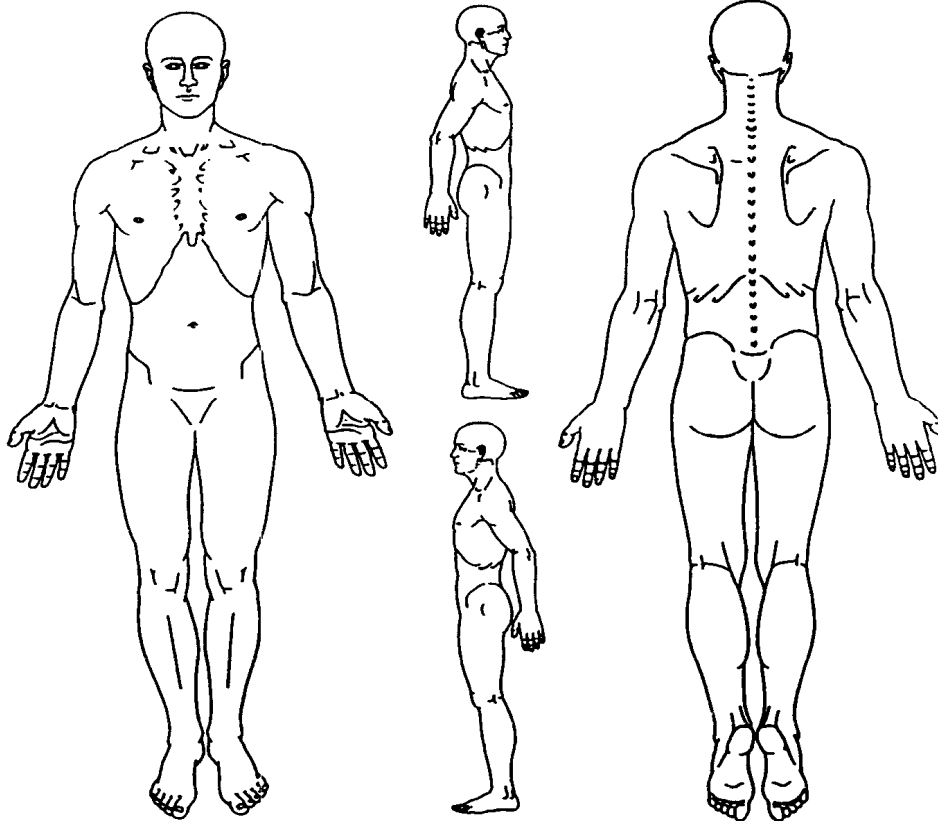
Is your sleep disturbed by these symptoms? YES NO
If you are restricted/limited or have difficulties in any activities or performance of your work because of your discomfort/pain, please describe in detail YES NO

Have you done anything to try to help or relieve your complaint, such as rest, heat, cold, aspirin, medication, sit, lie down. Or other?
 YES NO Describe in detail _____

Do you participate in other exercises (aerobics, walking, jogging, etc.)? YES NO
If yes, what type and how many times per week/month _____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache >>>>>	Numbness =====	Pins and Needles ↓↓↓↓↓↓	Burning ××××××
Stabbing ▽▽▽▽▽	Throbbing ~~~~~~	Tingling +++++	Sharp ↔↔↔↔↔
Dull 0 0 0 0 0	Soreness ○○○○○	Shooting ⊕ ⊕ ⊕ ⊕	Other



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort, please circle.

What is your pain/discomfort like today?
 What is your least pain/discomfort?
 What is your worst pain/discomfort?

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

How much time during an average day are you in pain/discomfort?

- Less than 1 hour per day
- Between 1 and 4 hours per day
- Between 4 and 8 hours per day
- Almost anytime that you are not lying down
- Almost 24 hours per day
- Other _____

If you are restricted/limited or have difficulties in any activities or performance at your home/activities of daily living or recreational activities because of your discomfort/pain, please describe in detail(such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) YES NO

Are you doing any corrective exercises for your present symptoms? YES NO

If yes, who recommended them? _____ Briefly describe the exercises/stretches you are doing

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic?

YES NO If yes, please list each doctor individually

A. If yes, whom did you see? Doctor's Name: _____ Specialty: _____
 Address: _____ City _____ State _____ Phone _____
 When were you seen? From _____ to _____ Are you still under this doctor's care? Yes No
 Were X-ray MRI CAT Scan EMG Bone scan or others _____ taken?
 What was diagnosis? _____ What
 type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections,
 surgeries, physical therapy and others) _____
 _____ How
 much were your symptoms/discomforts helped? Please circle. No
 improvement 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

B. If yes, whom did you see? Doctor's Name: _____ Specialty: _____
 Address: _____ City _____ State _____ Phone _____
 When were you seen? From _____ to _____ Are you still under this doctor's care? Yes No Were
 X-ray MRI CAT Scan EMG Bone scan or others _____ taken?
 What was diagnosis? _____ What
 type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections,
 surgeries, physical therapy and others) _____
 _____ How
 much were your symptoms/discomforts helped? Please circle. No
 improvement 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physical therapist for this problem? YES NO

If yes, whom did you see? Name: _____ Address: _____

What type of therapies were received? _____

How much were your symptoms/discomforts helped? please circle.

No improvement 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physician, chiropractor or physical therapist for any other problems? YES NO

If yes, please describe _____

Are you aware of any blood relatives with **similar** discomforts/problems?

No YES, please describe _____

Any family history of diseases or death of parents, siblings and children (e.g. heart problems, diabetes, asthma, hereditary disease etc.)

No YES _____

Please list all major past diseases and accidental injuries (include concussions, head injuries, broken bones, high blood pressure, etc.) you may have had which did not require hospitalization (please include dates and any recurring problems)

<u>Illness/injury</u>	<u>Date</u>	<u>Recurring</u>

Have you ever been involved in injuries from following:

Automobile accident Worker's compensation Personal injuries (slip and fall, etc.)

Yes No If yes, please list all of them with date, type, and legal status

<u>Injury</u>	<u>Date</u>	<u>Settled</u>	<u>Not settled</u>	<u>Attorney's name</u>

Please list all surgeries/operations you have ever had. Please also list when these were done, where they were done, who the surgeon was, and if you have had any remaining problems associated with these procedures. (Attach separate sheet if necessary.)

<u>Date</u>	<u>Type of surgery</u>	<u>Where</u>	<u>Surgeon's name</u>	<u>Complications</u>	<u>Remaining problems</u>

Please list all hospitalizations you have had in the past which did not involve surgery and remaining problems you attribute to these illnesses:

<u>Date</u>	<u>Cause of hospitalizations</u>	<u>Remaining problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take, and how long you have taken it.

<u>Medication</u>	<u>How often</u>	<u>How much</u>	<u>For how long</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to anything (medications, lotion, etc.)? YES NO

If yes, to what? _____

Do you smoke or use any tobacco products? If yes, how much & often? _____

Do you drink alcoholic beverages? If yes, how Much & often? _____

Do you drink caffeinated beverages? If yes, how much & often? _____

Do you exercise? YES NO Daily 3-4 Days a week 1-2 Days a week Less than 1 day a week

Do you eat healthy foods? YES NO Do you take Vitamins? YES NO

Please circle your level of formal education group

Less than High School

High School Diploma or GED

Some College

College Degree

Advanced Degree

Vocational Training in _____

Have you missed any work as a result of this illness/pain? YES NO

If yes, how many days/weeks? _____ Dates of absence _____ to _____

What type of physical activities or postures does your job involve (prolonged sitting, standing, bending, etc.)

Please list all and any other health problems you have had in the past or have now (such as headache, dizziness, blurred vision, vertigo, heart attack, high blood pressure, stomachache, vomiting, bloody stool, kidney infection, pneumonia, asthma, etc.).

<u>Illness/discomforts</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____

Women only

a. Are you pregnant or think you may be pregnant? _____

b. Date of last menstrual period _____

c. Do you or have you suffered from any menstrual disorders? YES NO

If yes, please describe _____

Who is filling out this questionnaire? Self Spouse Other _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature _____ Date _____

Physician's Signature (upon review) _____ Date _____

Dr. Joseph A. Sheppard, DC

PHYSICIAN'S NOTES: (over)

HISTORY IS TAKEN FROM PATIENT SPOUSE OTHER

INFORMATION IS RELIABLE NOT RELIABLE SATISFACTORY NOT SATISFACTORY.