Adult Patient Questionnaire:

Visit Date: ______________________________

NAME: ________________ ________________ MR#______________________________
Last First for office use only

DOB: _______________ Are you: Right handed □ Left Handed □
Who referred you to our office? Please circle one: MD NP PA PT ATC Coach
Name: ____
Address:____
Would you like a copy of today's note sent to the referral source? Yes□ No□
Do you have a Family Doctor (PCP)? Yes□ No□ If yes, please note:
Doctor's Name: ____
Doctor's Address:____
____
Are you: Married□ Single□ Divorced□ Widowed□ Other____________________
Are you currently employed? Yes□ No□ Occupation: ______________________________________
Are you retired? Yes□ No□ Are you disabled? Yes□ No□
Is the current problem a workplace injury? Yes□ No□ If yes, date injury occurred __________
If yes, Worker's Compensation Information:
Date of Injury: ________________Carrier Case#:______________________________________
Is the current problem the result of a motor vehicle accident? Yes□ No□
If you have been unable to work, please give the first date of disability: _________________________
Is there a lawsuit pending? Yes□ No□
Are you a student? Yes□ No□ If yes, what school _______________what grade____________
Do you play sports? Yes□ No□ If yes, what sport(s)/position(s) __________________________
Chief Complaint: ____
____

Do you have any pain at rest? Yes□ No□
Pain Intensity Scale: 0□ 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□
Do you have any pain with activity? Yes□ No□
Pain Intensity Scale: 0□ 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□
When did the problem start? ____
How did the problem start? ____
____
Are your symptoms currently: Getting better □Getting worse □ Staying the same□
Describe your treatment so far:____

MEDICAL HISTORY:

Operations:____
____
Medical Illnesses:____
____
Drug Allergies:____
Latex Allergy: Yes□ No□ Metal Allergy: Yes□ No□ Contrast Allergy: Yes□ No□
List all medications taken regularly:____
____
____

FAMILY HISTORY:

Does anyone in your family (blood relatives) have the following:

Diabetes Mellitus	Yes□ No□	Bleeding Disorders	Yes□ No□
Heart Disease	Yes□ No□	Reactions to Anesthesia	Yes□ No□
TB (tuberculosis)	Yes□ No□	Cancer	Yes□ No□
Hip dislocation	Yes□ No□	Genetic disorder	Yes□ No□
Multiple sclerosis	Yes□ No□	Scoliosis	Yes□ No□

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Childhood Arthritis Yes□ No□
Other:____

SOCIAL HISTORY:
Do you smoke? Yes□ No□ If yes, how many packs a day?____________________
How many years?________________
Did you ever smoke? Yes□ No□ If yes, how many packs a day?__________________
How many years?________________ When did you quit? ____________________
Do you drink alcohol? Yes□ No□ If yes, how much per week?____________________
Do you use recreational drugs? Yes□ No□ If yes, list drug(s) and frequency ______________

____
What are your hobbies, recreational activities, sports?______________________________
____

REVIEW OF SYSTEMS:
(check all that apply)

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores
□ Jaw problems

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Respiratory-
□ Cough
□ Sputum
□ Shortness of breath
□ Asthma
□ Sleep apnea

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Swelling

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping
□ Deep Vein Thrombosis

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling

Hematologic-
□ Ease of bruising/bleeding
□ HIV
□ Hepatitis C

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Patient Signature: **Date:**

Physician Signature: