New Patient Questionnaire

Name: _____
Age: _____
Right or Left Handed? _____
Primary Care Doctor: _____
Address: _____
Occupation (if working):_____
Current work status (full duty, light duty, modified) _____

List all medical illnesses: indicate with a "Y" (yes) or "N" (no):

____Anemia	____Stomach Ulcers	____Leg Cramps
____Arthritis	____Excessive bleeding	____Phlebitis
____Asthma	____Heart problems	____Rheumatic fever/murmur
____Birth Control Pills	____High Blood pressure	____Varicose veins
____Circulation problems	____Hormone therapy	____HIV or Aids
____Diabetes	____Kidney or Liver problems	____Thyroid problems

Any others:_____

List any sports that you do and at what level:
_____
_____

List all previous surgeries, surgeon's names and approximate date:
_____
_____
_____

List all current medications and doses:
_____
_____

Allergies to medications or latex?
_____
_____

Do you smoke? If so how much?
_____
_____

Do you drink? If so how much?
_____
_____

Which is the main problem for which you are seeing us today?
_____
_____

When did you first begin to have this problem? (Specific date)_____
_____

Injuries/illnesses you feel are related to the problem for which you are being seen today?
_____
_____

List names and dates of all doctors you have seen for this problem
_____
_____

Treatments you have had for this. (Medications, physical therapy, splints, injections, etc.)_____

Have you had other treatments such as chiropractic, acupuncture, massage, etc? Please list with dates:
_____
_____

Was this a work-related illness/injury or accident? _____

Was this illness/injury or accident the result of a motor vehicle accident?
_____
_____

Specific date of motor vehicle accident:
_____
_____

I certify that the information provided, here in, is true and correct to the best of my knowledge.

Signature: _____

Date: _____