Name: _____ Date: _____

Initial Questionnaire

HISTORY OF PRESENT CONDITION

1. What are your symptoms / complaints? _____

2. Date of onset: _____ Surgery date (if applicable): _____

3. Which of the following **caused** your injury? (check all that apply)

- ☐ Lifting
- ☐ MVA (car accident)
- ☐ Fall
- ☐ Repetition / Overuse
- ☐ Work Related
- ☐ Trauma
- ☐ Degenerative process
- ☐ Recreation / Sports
- ☐ Running
- ☐ Throwing
- ☐ Dental appointment
- ☐ Surgery
- ☐ Following illness
- ☐ Unknown
- ☐ Other (list below)

_____

_____

4. **Describe** your pain/symptoms (check all that apply)

- ☐ Sharp
- ☐ Burning
- ☐ Periodic
- ☐ Constant
- ☐ Intermittent
- ☐ Dull / Achy
- ☐ Throbbing
- ☐ Other: _____

5. Other Medical Symptoms? (check all that apply)

- ☐ Bowel / Bladder changes
- ☐ Fever / Chills
- ☐ Genital / Anal numbness
- ☐ Numbness
- ☐ Dizziness / Fainting attacks
- ☐ Weakness
- ☐ Weight gain / loss
- ☐ Night pain / sweats
- ☐ Malaise or fatigue
- ☐ Vision / Hearing problems
- ☐ Changes in balance / falls
- ☐ List other below

_____

_____

6. Have you had any previous treatment for this condition? (check all that apply)

- ☐ None
- ☐ Medication
- ☐ Chiropractic Care
- ☐ Exercise
- ☐ Massage therapy
- ☐ Heat or Ice
- ☐ Bracing / taping
- ☐ Injection
- ☐ Traction
- ☐ Physical Therapy
- ☐ Hypnosis
- ☐ Biofeedback
- ☐ TENS unit
- ☐ Acupuncture
- ☐ Bed Rest
- ☐ Overnight hospitalization
- ☐ Casting
- ☐ List other below

_____

_____

7. Have you had any of the following **diagnostic** tests for this condition? (check all that apply)

- ☐ None
- ☐ X-rays
- ☐ CT scan
- ☐ MRI
- ☐ Arthrogram
- ☐ Vestibular
- ☐ Bone Scan
- ☐ Fluoroscope
- ☐ Other: _____
- ☐ EMG
- ☐ Nerve Conduction

Name: _____ Date: _____

8. Medical History (check all that apply and please specify)

- ☐ Diabetes
- ☐ DVT / Blood Clots
- ☐ Heart Problems (specify)
- ☐ High Blood Pressure
- ☐ Pacemaker / Defibrillator
- ☐ Lyme Disease
- ☐ COPD / Emphysema
- ☐ Asthma
- ☐ Cancer (specify)
- ☐ Stroke / TIA
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fracture
- ☐ Multiple Sclerosis (MS)
- ☐ Parkinson's Disease
- ☐ Psychological Issues
- ☐ Allergies (specify)
- ☐ Dizziness / Vertigo
- ☐ Circulation Problems
- ☐ Stomach Problems
- ☐ Blood Disorder
- ☐ Thyroid Problems
- ☐ Epilepsy / Seizures
- ☐ Kidney Problems
- ☐ Infectious Disease
- ☐ Obesity
- ☐ Other: _____

Specify: _____

_____

MEDICATION

Please list all current medications as best you can (or provide a list): _____

_____

_____

_____

_____

EMPLOYMENT

☐ Currently Employed ☐ Retired / Not Employed

INSURANCE REQUIRED INFORMATION

1. Do you currently use tobacco ☐ Yes ☐ No or alcohol ☐ Yes ☐ No
2. Do you feel confident in your ability to overcome or manage this problem? ☐ Yes ☐ No
3. Do you perform an exercise program 3 or more times per week? ☐ Yes ☐ No
4. Have you received Physical / Occupational Therapy within the past year? ☐ Yes ☐ No # of visits: ____
5. Have you received Chiropractic care within the past year? ☐ Yes ☐ No # of visits: _____

EMERGENCY INFORMATION

Emergency Contact Name: _____

Telephone Number: _____

Relationship to Patient: _____