



# NEW PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_



Date: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_

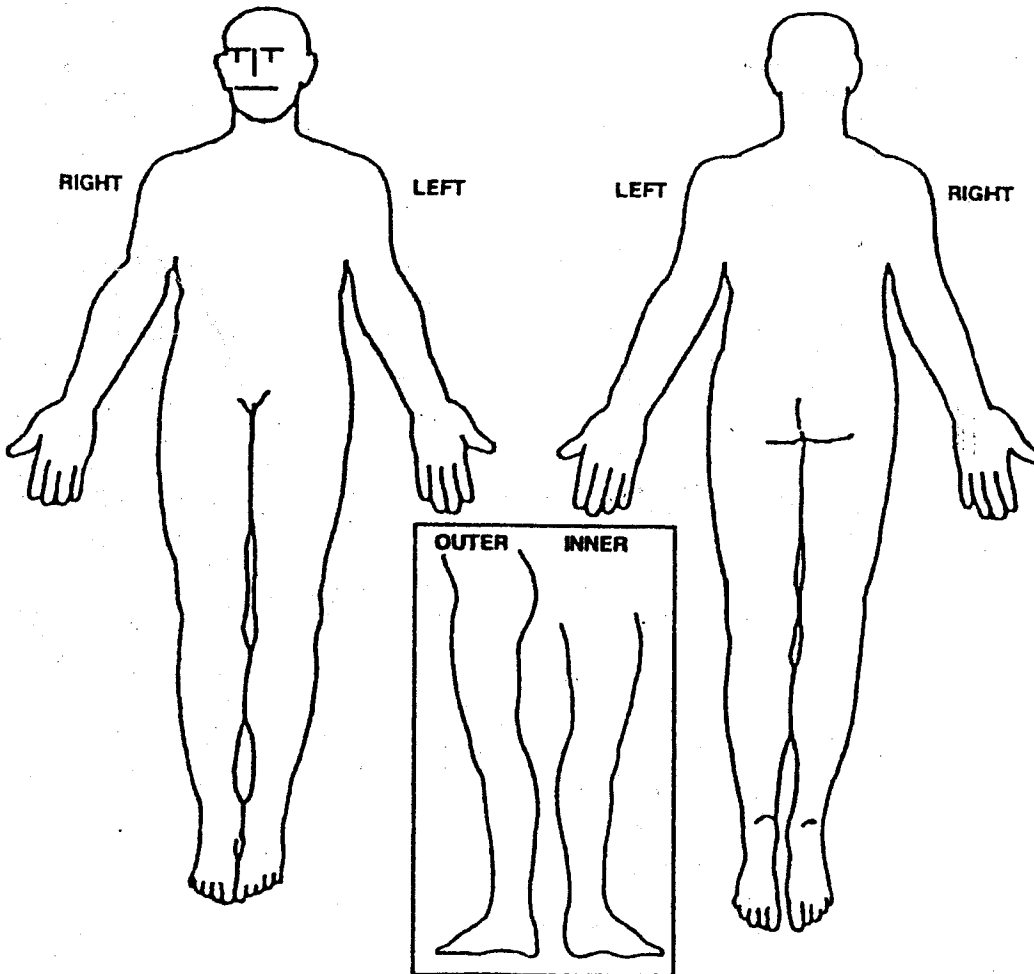


Mark these drawings using the symbol that best describes your pain

Numbness      
Stabbing    

Ache          
Burning     

Pins and Needles      
Cramping            





9 How do the following activities affect your symptoms? Circle a number for each activity.  
 0 represents no increase in symptoms      10 a significant increase in symptoms

1 Sitting	0	1	2	3	4	5	6	7	8	9	10
2 Standing	0	1	2	3	4	5	6	7	8	9	10
3 Rising from sitting	0	1	2	3	4	5	6	7	8	9	10
4 Bending forward	0	1	2	3	4	5	6	7	8	9	10
5 Bending backward	0	1	2	3	4	5	6	7	8	9	10
6 Walking	0	1	2	3	4	5	6	7	8	9	10
7 Lying on your back	0	1	2	3	4	5	6	7	8	9	10
8 Lying on your stomach	0	1	2	3	4	5	6	7	8	9	10
9 Coughing and sneezing	0	1	2	3	4	5	6	7	8	9	10
10 Reaching overhead	0	1	2	3	4	5	6	7	8	9	10
11 Lifting from the floor	0	1	2	3	4	5	6	7	8	9	10

10 I can sit in a chair for:

- 1 Less than 5 minutes \_\_\_\_\_
- 2 5-15 minutes \_\_\_\_\_
- 3 15-30 minutes \_\_\_\_\_
- 4 30-60 minutes \_\_\_\_\_
- 5 As long as I want \_\_\_\_\_

11 I can stand for:

- 1 Less than 5 minutes \_\_\_\_\_
- 2 5-15 minutes \_\_\_\_\_
- 3 15-30 minutes \_\_\_\_\_
- 4 30-60 minutes \_\_\_\_\_
- 5 As long as I want \_\_\_\_\_

12 I can walk for:

- 1 Less than 5 minutes \_\_\_\_\_
- 2 5-10 minutes \_\_\_\_\_
- 3 15-30 minutes \_\_\_\_\_
- 4 30-60 minutes \_\_\_\_\_
- 5 As long as I want \_\_\_\_\_

13 Do you use a cane, walker, or a wheelchair? Y / N

	Inside the house	Outside the house
Cane	_____	_____
Walker	_____	_____
Wheelchair	_____	_____

14 Have you been treated for your symptoms? Y / N

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Have you ever had back/neck surgery? Y/ N. If yes, how many surgeries? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Describe your current work status:

1. I am currently working full time
2. I am currently working part time
3. I am not working because of my current symptoms
4. I am not working for a reason other than my current symptoms
5. Date I last worked \_\_\_\_\_
6. If you are still working, do your current symptoms affect your work or do you have pain while working? Y / N
7. What kind of work do you do? \_\_\_\_\_
8. How much work have you missed because of your current symptoms or similar symptoms? \_\_\_\_\_

17. Has your pain restricted your social and recreational life? Y / N

Brief Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Have you hired a lawyer because of your condition? Y / N

19. Do you currently smoke cigarettes? Y / N      How much packs a day? \_\_\_\_\_  
Do you currently use snuff or chew? Y / N      How much snuff or chew? \_\_\_\_\_

20. Do you use alcohol? \_\_\_\_\_ Type? \_\_\_\_\_ Amount? \_\_\_\_\_

21. Education:

- |                  |       |
|------------------|-------|
| 1 High school    | Y / N |
| 2 2 year college | Y / N |
| 3 4 year college | Y / N |
| 4. Post 4 years  | Y / N |

22. Martial Status              Married    Single    Divorced    Widowed

23. Do you live alone. With family members or friends ( Circle one ).

24. Family history

	Mother	Father	Brothers	Sisters	Children
Heart disease					
High blood pressure					
Stroke					
Cancer					
Diabetes					
Glaucoma					
Epilepsy					
Bleeding disorders					
Kidney disease					
Thyroid disease					
Mental illness					
Osteoporosis					
Back problems					
Living					
Deceased / caused					

Thank you for your cooperation.

Ht	_____
Wt	_____
B/P	_____
T	_____
P	_____
R	_____

## PMH/PSH/ROS

### Neurologic

	Y	N
Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>

Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>

### Respiratory

	Y	N
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Lung/Respiratory infections	<input type="checkbox"/>	<input type="checkbox"/>

Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>

### Cardiovascular/Peripheral Vascular

	Y	N
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Stasis ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Raynaud's	<input type="checkbox"/>	<input type="checkbox"/>

Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>

### Hematopoietic/Immune

	Y	N
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Polycythemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis/disorders	<input type="checkbox"/>	<input type="checkbox"/>
Previous blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>

HIV	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>

Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>

### Visual

	Y	N
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>

Visual difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Blurred/double vision	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>

### Ear/Nose/Throat

	Y	N
Ear		
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>

### Nose

Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
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### Throat

Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Vocal cord paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Strep throat	<input type="checkbox"/>	<input type="checkbox"/>

### Gastrointestinal

	Y	N
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
GI bleed	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Cholecystitis	<input type="checkbox"/>	<input type="checkbox"/>

Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

**Genitourinary**

	Y	N
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
UTI	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>

Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Urinary retention	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>

**Endocrine/Metabolic**

	Y	N
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal problems	<input type="checkbox"/>	<input type="checkbox"/>
Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>

	Y	N
Recent weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>

**Integumentary**

	Y	N
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Skin CA	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>

Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>

**Musculoskeletal**

	Y	N
Fractures/Lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Fractures/Upper extremities	<input type="checkbox"/>	<input type="checkbox"/>
Fractures/Spine	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Joint swelling/Redness/Pain	<input type="checkbox"/>	<input type="checkbox"/>
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**Lymphatic**

	Y	N
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>

**Psychiatric**

	Y	N
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>

Please list any surgeries that you have had.

Allergies to Medications? Y/N

Please list:

Current medications

Dosage