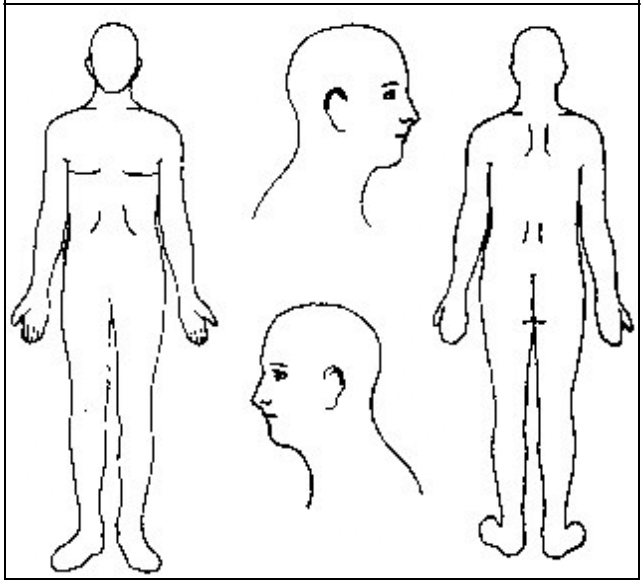
Health Questionnaire

Name (Please Print): _____

Date: ___/___/___ **Is your injury from Work Compensation or Auto Accident? Yes or No**

Place an "X" on the drawing below on areas causing you pain and the letter describing it.

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Surgeries	
Year	Reason

Daily Medications		
Blood Pressure ☐	Diabetic ☐	Birth Control ☐
Thyroid ☐	Muscle Relaxer ☐	Antidepressant ☐
Anxiety ☐	Heart ☐	Pain ☐
Steroids ☐	Cholesterol ☐	Antibiotics ☐
Other(s):		

Current Condition	
Reasons (s) for today's visit:	
What contributed to this injury:	
When did your symptoms start:	Is the condition getting: Better ☐ Worse ☐ No Change ☐
Have you had this before: Yes ☐ No ☐	Does the pain increase or keep you up at night: Yes ☐ No ☐
How would you describe the pain frequency: constant ☐ come & go ☐	
Does it interfere with: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Personal ☐	
Activities that are painful/difficult to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending	
Have you been treated for this condition before: Yes ☐ No ☐ If yes, by whom:	

Family History				
Relation	**Living**	**Deceased**	**Age**	**Health Conditions**
Father				
Mother				
Sister (s)				
Brother (s)				

Other Problems / Conditions					
Place an "X" if you have, or have had any condition or problems with any of the following.					
Stroke		Chest Pain		Gout	
Headaches		Neck Pain		Weight (Rapid loss or gain)	
Dizziness		Mid Back Pain		Ringing in ears	
High Blood Pressure		Low Back Pain		Ability to sleep	
Circulation		Leg or Thigh Pain		Depression	
Neurological Disease / Seizures		Disc or Sciatica		Stress	
Broken Bones		Irritable Bowel Syndrome		Alcoholism	
Osteoporosis		Difficulty Urinating (flow or pain)		Kidney (problems or stones)	
Diabetes		Pins & Needles Sensation		Other:	

Lifestyle / Habits	
Exercise: Sedentary (none) ☐ Mild (walk/golfing) ☐ Occasional (1-2xweek) ☐ Regular (4x/week) ☐	
How many hours of sleep do you get a night (average)	Position: Side ☐ Back ☐ Stomach ☐
Do you smoke: No ☐ Yes ☐ , How much:	Use recreational/street drugs: Yes ☐ No ☐
Do you drink alcohol: No ☐ Yes ☐, How often & What kind:	Drinks per/week :
Do you feel safe at home, work , school: Yes ☐ No ☐	
Is stress a major problem for you: Yes ☐ No ☐	Ever seen a counselor: Yes ☐ No ☐
Caffeine: None ☐ Coffee ☐ Tea ☐ Cola ☐ Energy Drinks ☐ # of cups/cans per day:	
Do you use any form of Birth Control: N/A ☐ No ☐ Yes ☐ If yes, what kind:	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Name **Date**