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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

GENERAL

Name	*Last Name*	*First Name*	*M.I.*	Today's Date (MM/DD/YYYY) / /

Gender ☐ Male ☐ Female	Height	Weight	Age	Which is your dominant hand? ☐ Left ☐ Right

Referring Doctor & Phone	Primary Care Doctor & Phone

Have you been discharged from an inpatient facility in the past 30 days? If yes:

What was your date of discharge?

Were any of your medications changed?

CURRENT PROBLEM

What part of your body are you being seen for today?

Which side? (if applicable) ☐ Left ☐ Right

What is the goal of your appointment today?

☐ Pain Management ☐ Better Function ☐ Better Appearance ☐ Return to Work ☐ Return to Play ☐ Other: ______________________________

How did the problem develop?

When did the problem start: ☐ Over Time (Duration:__________________) ☐ Injury (Date of Injury: ____________________)

Is this work related? ☐ Yes ☐ No

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: ☐ Numbness? ☐ Tingling? If yes, where:

Have you noticed any weakenss? ☐ Yes ☐ No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? ☐ Yes ☐ No If yes, explain:

Do your symptoms affect your activities of daily living? ☐ Yes ☐ No If yes, explain:

Do your symptoms keep you awake at night? ☐ Yes ☐ No

What treatments have you tried? ☐ Injection ☐ Physical Therapy ☐ Chiropractic ☐ Medication:__________________ ☐ Other: ____________

Have any treatments helped? ☐ Yes ☐ No Please explain:

How many street blocks can you walk?

Do you use a walking device? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheel Chair ☐ Not Applicable; Don't use a walking device

Describe how you use stairs: ☐ Place one foot per step ☐ Place both feet on step before proceeding to next ☐ Not Applicable; Don't use stairs