New Patient Questionnaire
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Height _________
Weight _________

It is important to us that we provide you with the best care and service possible. Please take a moment to answer each question as accurately as possible. The information you provide will be beneficial in determining your medical care and treatment.

Date ________________ Name: __________________________________ Birth Date: _________________ Age: ______

Who referred you ☐Physician ___________________________ ☐Emergency Room ☐Self ☐Other: ____________
(Full Name)

Primary physician/location: ____

Reason for visit: ____

Any other questions you would you like answered today: ____

Where is your pain: ____

How long have you had pain for? _______________________ Onset of Symptoms: ☐Gradual ☐Sudden

If an injury, briefly describe how injury occurred: ____

Date of Injury: _____________________ ☐ Workers Compensation ☐ Automobile Accident

Pain Scale: (on 1-10 scale, 10 being worst possible) At its worst ____________ At its best ______________

What makes your pain worse: ____

What makes your pain better: ____

Have you had similar pain before: ___________When: ____

Have you had any pain in these areas previously: ___________When: ____

What, if any, treatments have you had for your current problem: ____

Any previous surgery: ☐Yes ☐No If yes, describe: ____

Current Medications / Herbal / Natural medications:____

List sporting/recreational activities you participate in: ____

Review of Health: Please check if you are CURRENTLY experiencing any of the following:

☐Weight loss of more than 10 pounds in past year EXCLUDING dieting

☐Fever or night sweats	☐Fatigue	☐Headaches	☐Incoordination/imbalance
☐Dizzy spells	☐Ringing in ears	☐Frequent urination	☐Painful urination
☐Visual changes	☐HIV/AIDS	☐Circulatory problems	☐Concussion /recent head injury

When was last menstrual period _________ or ☐Post-menopausal

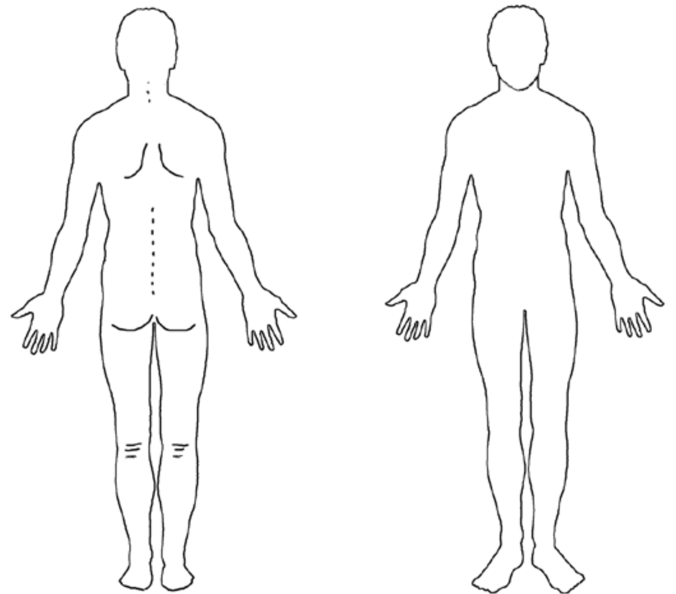
Medical History: Please check if you or your family members (indicate which one) have any of the following:

	Self	Family	Description/Comments
Asthma	☐	☐	________________
Arthritis/ Gout	☐	☐	________________
Rheumatoid disease	☐	☐	________________
Bleeding tendency	☐	☐	________________
Heart disease	☐	☐	________________
High blood pressure	☐	☐	________________
Diabetes	☐	☐	________________
Kidney disease	☐	☐	________________
Neurological/nerve disease	☐	☐	________________
Liver disease	☐	☐	________________
Mental Health issues	☐	☐	________________
Other	☐	☐	________________

Pain Diagram:
Please draw in wherever you are feeling any of the following symptoms: Use the following symbols:
Pain (+)
Numbness (–)
Tingling (o)
Burning (x)

What percentage of your pain is in these areas:
Back %
Buttock / leg %

Neck %
Shoulder / Arm %



Detailed Job Status:
☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ On disability
You are on ☐ regular duty ☐ modified duty ☐ full time ☐ part time
Occupation & brief description: ________________________________
Your job title ________________________________

Duration of time off from ________________ to ________________
Your last day worked ________________________________

Tests Done So Far For Spine Related Symptoms:

	Approximate date	Center/Doctor's office
X-rays	__________	________________
MRI scan	__________	________________
CT scan	__________	________________
Bone scan	__________	________________
Myelogram	__________	________________
EMG nerve conduction test	__________	________________
Arthritis blood test	__________	________________

Any Previous Neck/Back Problems:

Previous motor vehicle accidents	( ) YES	( ) NO
Previous workmen's compensation cases	( ) YES	( ) NO
Pending / ongoing litigation?	( ) YES	( ) NO

Please describe: ________________________________

Patient Signature: ________________________________ Date: __________

Physician Review: ________________________________ Date: __________