NEW PATIENT INTAKE QUESTIONNAIRE

NEW EST CONS

Name: _____ **DOB: _____**
Primary Doctor: _____ **AGE: _____** **Date: _____**

Referred By:_____❑ER(name)_____Date seen:_____
Current work status? ❑Retired ❑Regular ❑Light duty (How long?_____) ❑Not working due to this problem
Date last worked regular job?_____ **Occupation?** _____
Dominant Hand: ❑R ❑L

Main REASON FOR TODAY'S VISIT: ❑Pain ❑Numbness ❑Weakness ❑Swelling ❑Stiffness
Body Part involved: _____

❑ Neck	Radiating to	❑R arm ❑L arm ❑Neither	Shoulder	❑R ❑L	Arm	❑R ❑L	Elbow	❑R ❑L	Wrist	❑R ❑L	Hand	❑R ❑L	Finger T 2 3 4 5 ❑R ❑L
❑ Back	Radiating to	❑R leg ❑L leg ❑Neither	Pelvis	❑R ❑L	Hip	❑R ❑L	Knee	❑R ❑L	Leg	❑R ❑L	Ankle Foot	❑R ❑L	Toe B 2 3 4 5 ❑R ❑L

Date of Onset:_____ **Has been going on for?**_____days _____wks _____mos. _____yrs

HOW DID THIS PROBLEM START: (pick ONE)	DESCRIBE:
❑ NO INJURY (Onset: ❑gradual ❑sudden) Why do you think it started?	
❑ AUTO ACCIDENT Date_____ Describe:	
❑ INJURY (❑Accident ❑Sport NOT Auto/Work) Date_____; Where/how did happen? Sport_____School_____	
❑ WORK RELATED INJURY Date:_____ ❑lift ❑slip ❑twist ❑fall ❑pull ❑reach	

CHARACTERISTICS:
Pain Severity (on scale 0-10; 10=worst): When pain is **Worst** _____/10 **;** When pain is **Best** _____/10
Pain Quality: ❑Sharp ❑Dull ❑Stabbing ❑Throbbing ❑Aching ❑Burning ❑Electric ❑Other_____
Pain Duration/Character: ❑Constant ❑Intermittent ❑Activity Related ❑Worse in AM ❑Worse at night
Does pain wake you from sleep? ❑Y ❑N
Do you have? ❑Swelling ❑Bruising ❑Numbness ❑Tingling
Has this problem occurred before? ❑Y ❑N; (describe)_____
This problem is getting: ❑better ❑worse ❑staying same
What makes symptoms *BETTER* ❑Rest ❑Elevation ❑Ice ❑Heat ❑Other_____
What makes symptoms *WORSE*: ❑Lifting❑Exercise ❑Twisting ❑Bend ❑Standing ❑Walking ❑Squat ❑Kneel ❑Stairs ❑Sitting ❑_____
What TESTS have you had for this problem: ❑X-rays ❑MRI ❑CT ❑Bone Scan ❑DEXA ❑EMG/NC

Previous TREATMENTS for this Problem:

Prev. Treatments:		Made Problem:	Details:(Name,# treatments,location)
❑Y ❑N	Medications	❑better ❑worse ❑same	
❑Y ❑N	Injection	❑better ❑worse ❑same	
❑Y ❑N	Brace	❑better ❑worse ❑same	
❑Y ❑N	Therapy	❑better ❑worse ❑same	
❑Y ❑N	Chiropractic	❑better ❑worse ❑same	
❑Y ❑N	Cane/Crutch	❑better ❑worse ❑same	
❑Y ❑N	Surgery	❑better ❑worse ❑same	
❑Y ❑N	Other	❑better ❑worse ❑same	