PATIENT QUESTIONNAIRE

FULL NAME

DATE SYMPTOMS STARTED

DATE OF SURGERY *(if applicable)*

INJURY & GOALS

Which of the following best describes how your injury occured?

- ☐ A fall
- ☐ An accident
- ☐ Degenerative process
- ☐ Dental appointment
- ☐ Car accident (state occurred):
- ☐ During recreation/sport
- ☐ Lifting
- ☐ Overuse (cumulative trauma)
- ☐ Unknown
- ☐ Other:

What's your primary goal?

☐ Return to work ☐ Return to sport ☐ Prevent procedure

☐ Return to daily activities ☐ Other:

PAIN & SYMPTOMS

What's the nature of your complaint?

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Dull
- ☐ Intermittent
- ☐ Numbness/tingling
- ☐ Pain
- ☐ Sharp
- ☐ Throbbing
- ☐ Weakness
- ☐ Other:

Since your symptoms began, they have:

☐ Improved ☐ Worsened ☐ Stayed the same

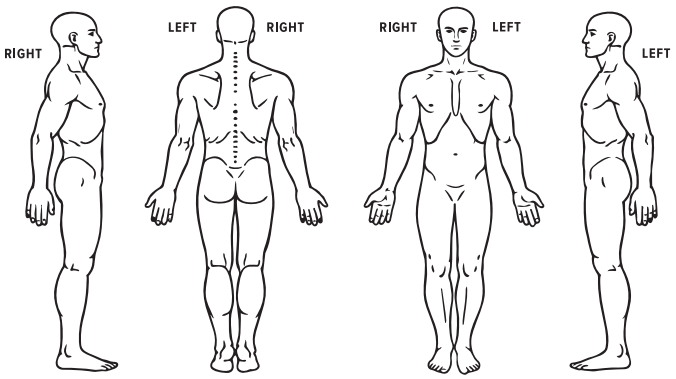
As the day progresses, your symptoms:

☐ Improve ☐ Worsen ☐ Stay the same

Circle the level of pain you are experiencing.

LOW 1 2 3 4 5 6 7 8 9 10 HIGH

Please circle area(s) where pain is occurring.



What relieves (R) or aggravates (A) your symptoms? *(Mark R or A)*

- ____ Coughing/sneezing
- ____ Cold
- ____ Exercise
- ____ Heat
- ____ Lying down
- ____ Massage
- ____ Nothing
- ____ Rest
- ____ Sitting
- ____ Standing
- ____ Stretching
- ____ Walking
- ____ Wearing a splint

Other:

DAILY FUNCTION

What position do you sleep in?

☐ Back ☐ Back and side ☐ Chair/recliner

☐ Left side ☐ Right side ☐ Stomach

Do you have any pain or stiffness getting out of bed?

☐ Yes ☐ No

Since your symptoms began, have you had:

- ☐ Bladder or bowel difficulty
- ☐ Dizziness or fainting
- ☐ Fever or chills
- ☐ Headache
- ☐ Nausea or vomiting
- ☐ Night sweats or pain
- ☐ Genital or anal area numbness
- ☐ Vision, hearing, or speech issues
- ☐ Unexplained weight changes
- ☐ Weakness
- ☐ None
- ☐ Other:

Current limitations *(check all that apply):*

- ☐ Bending
- ☐ Going from sit to stand
- ☐ Home activities
- ☐ Looking overhead
- ☐ Lying down
- ☐ Reaching
- ☐ Self-care/hygiene
- ☐ Sitting
- ☐ Sports/recreation
- ☐ Squatting
- ☐ Standing
- ☐ Swallowing
- ☐ Taking a deep breath
- ☐ Talking
- ☐ Chewing/yawning
- ☐ Up/down stairs
- ☐ Walking
- ☐ None

TREATMENT & CARE HISTORY

Check/list previous treatments for this condition:

- ☐ Biofeedback/TENS
- ☐ Bracing/taping
- ☐ Chiropractic
- ☐ Hospitalization
- ☐ Injection/acupuncture
- ☐ Massage
- ☐ Medication
- ☐ Physical therapy
- ☐ None
- ☐ Other:

Check/list any other health care providers currently involved:

- ☐ Chiropractor
- ☐ Dentist
- ☐ Medical doctor
- ☐ Physical therapist
- ☐ Podiatrist
- ☐ VA doctor
- ☐ None
- ☐ Other:

Check/list any of the following imaging tests you've had:

- ☐ CT scan
- ☐ EMG
- ☐ MRI
- ☐ X-ray
- ☐ None
- ☐ Other: