Back & Neck Wellness Center

4222 Milwaukee Street, Suite 83 ▪ Madison, WI 53714

NEW PATIENT QUESTIONNAIRE

TODAY'S DATE:_____

NAME: _____ CELL PHONE: (_____)_____

ADDRESS: _____ DATE OF BIRTH: ____/____/_____

CITY: _____ ST: _____ ZIP CODE: _____

SYMPTOM/PAIN INFORMATION:

1. Please list the **primary** complaint for which you came to our office. *Describe the character of the symptoms. Some words often used include burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc.*:

_____

_____

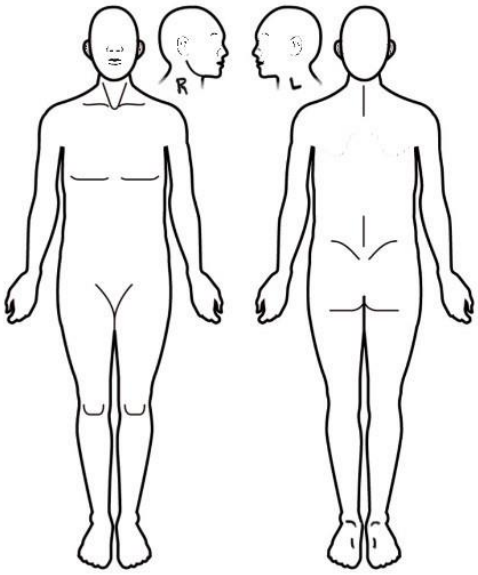
_____

2. Please list and describe the character of the symptoms of any **secondary** complaint(s) for which you came to our office. (*burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc*.): _____

_____

_____

3. Shade in the areas on the diagram where you feel discomfort or symptoms:



4. Please put a mark on the scale to show how bad your usual discomfort has been recently.

0	1	2	3	4	5	6	7	8	9	10

No Discomfort Worst Possible Discomfort

5. How long have you had this episode of symptom(s)?

_____

6. How many times have you had a problem similar to or the same as this in the past?

□ None previously □ 1-5 episodes □ 6-10 episodes □ More than 10 episodes

□ Single episode of continuous pain

7. When was the very first time you ever felt something similar to or the same as your current symptom(s)?

□ Less than 6 months ago □ 6 months – 1 year ago □ 1-5 years ago □ 5-10 years ago □ 10-20 years ago □ More than 20 years ago

8. Did the symptom(s) begin gradually over time, or suddenly? _____

9. Since symptom(s) began, have they: □ improved □ worsened □ stayed the same

10. How frequently do you have this pain? □ Constant (100% of the time) □ Frequent (more than 50% of the time)

□ Occasional (less than 50%, but more than 25% of the time) □ Intermittent (less than 25% of the time)

If there are any times or positions during which you do not experience pain/discomfort please explain (e.g. after exercising, while sleeping, etc): _____

11. What do you believe caused symptom(s) to occur (physical overuse, mental stress, accident, etc)? Please be specific.

_____

_____

12. What aggravates your current symptom(s)? _____

_____

13. Is your sleep disturbed by these symptoms? □ yes □ no

14. Do you sleep on a: □ mattress/box spring □water bed □ futon □ other _____

15. What is your normal sleeping position? □ back □side □ stomach □ other _____

16. If you are restricted/limited in any work, home, or recreational activities because of symptom(s), please describe:

_____

17. Are your symptom(s) the result of an auto accident, work injury, or other personal injury? □ yes □ no

If you answered yes, please fill out an accident specific form, available at the front desk.

18. Have you done anything to try to help relieve the discomfort? (example: rest, heat, cold, medications, sitting, laying down, or other) If so, please describe: _____

_____

19. Are you now doing corrective exercises for your present symptoms? □ yes □ no

If yes, who recommended them? _____

Briefly describe the exercises/stretches you are doing: _____

_____

20. Do you participate in any other exercises (walking, jogging, biking, etc.)? □ yes □ no

If yes, what type and how often? _____

21. Have you seen a chiropractor outside of this office for your current symptom(s)? □ yes □ no

If yes, whom did you see? _____ When were you seen? _____

Were x-rays taken? □ yes □ no

What type of treatment was performed? _____

How much did it help?

0	1	2	3	4	5	6	7	8	9	10

No improvement Full Improvement

22. Have you seen a physical therapist for this problem? □ yes □ no

If yes, whom did you see? _____ When were you seen? _____

Were x-rays taken? □ yes □ no

What type of treatment was performed? _____

How much did it help?

0	1	2	3	4	5	6	7	8	9	10

No improvement Full Improvement

23. Have you seen a chiropractor, physical therapist or osteopath for any other symptom(s)? □ yes □ no

If yes, please describe: _____

24. Are you aware of any blood relatives with similar symptom(s)? □ yes □ no

If yes, please describe: _____

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NEW PATIENT QUESTIONNAIRE

Medical History

1. Are you now, or have you suffered from the following? (Please write past, present or never in the blank space)

Arteriosclerosis_____	Double/Blurred Vision _____	Polio_____
Asthma_____	Epilepsy _____	Stroke_____
Arthritis_____	Heart Attack/Disease_____	Ear Infections_____
Cancer_____	High Blood Pressure_____	Rheumatic Fever_____
Diabetes_____	Migraines_____	Allergies_____
Dizziness/Fainting_____	Motion Sickness_____	Influenza_____
Anemia_____	Back Surgery_____	Fatigue (Chronic) _____
HIV Infection_____	Pleurisy_____	Sinus Trouble_____
Tuberculosis_____	Digestive Disorders_____	Pneumonia_____
Measles_____	Mumps_____	TMJ_____
Appendicitis_____	Thyroid Problems_____	Low Blood Pressure_____
Carpal Tunnel_____	Venereal Disease_____	Ulcer_____
Scarlet Fever_____	Hepatitis_____	Drug/Alcohol Dependence _____
Kidney Disease_____	Depression_____	Gout_____
Eczema_____	Broken Bones_____	
Chicken Pox_____	Multiple Sclerosis_____	

2. Are you pregnant, or think you may be pregnant? □ yes □ no
   Date of last menstrual period: _____
   Do you suffer from any menstrual disorders? □ yes □ no
   If yes, please describe: _____
3. Do you have any condition, disease or problem not listed above? □ yes □ no
   If yes, please describe: _____
4. Do you smoke or use any tobacco products? □ yes □ no
   If yes, how often? _____
5. Do you drink alcoholic beverages? □ yes □ no
   If yes, how often? _____
6. Do you drink caffeinated beverages? □ yes □ no
   If yes, how often? _____
7. Have you had any other serious illness/trauma (falls, accidents), surgeries, or been hospitalized? □ yes □ no
   If yes, please describe: _____
   _____
8. Please list all medications, including prescriptions, birth control pills, over the counter medications, vitamins, etc that you are currently taking: _____
   _____
   _____
   _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

➔ **Printed Name: _____**

➔ **Signature: _____ Date: ____/____/_____**