CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of this form. If you need assistance, please ask, and we will be happy to help you.

Name: _____ Date: _____

Address: _____

City: _____State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Age: _____ Date of birth: _____ E-Mail:_____

Marital status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Occupation: _____

Employer or retired from: _____

Spouse's name: _____

Spouse's employer: _____

Name of person to contact in an emergency: _____

Emergency contact's home phone: _____ Work phone: _____

Emergency contact's relationship to patient: _____

Who referred you to this office so we may thank them: _____

Family physician: _____ Phone no.:_____

What is your primary complaint? _____

_____

List any other doctors you have seen for this complaint._____

_____

Have you had any X-rays, MRI, CT scan? ❑ Yes ❑ No

Where?_____

Name:_____ Date:_____

Regarding your PRIMARY complaint:

When did it start? _____

How did it start? _____

How frequent is your pain/symptom? _____

How would you describe your pain/symptom (ie. dull, achy, sharp)? _____

Does it radiate into your arms or legs? _____

What activities/positions aggravate your complaint? _____

What activities/positions help reduce your complaint? _____

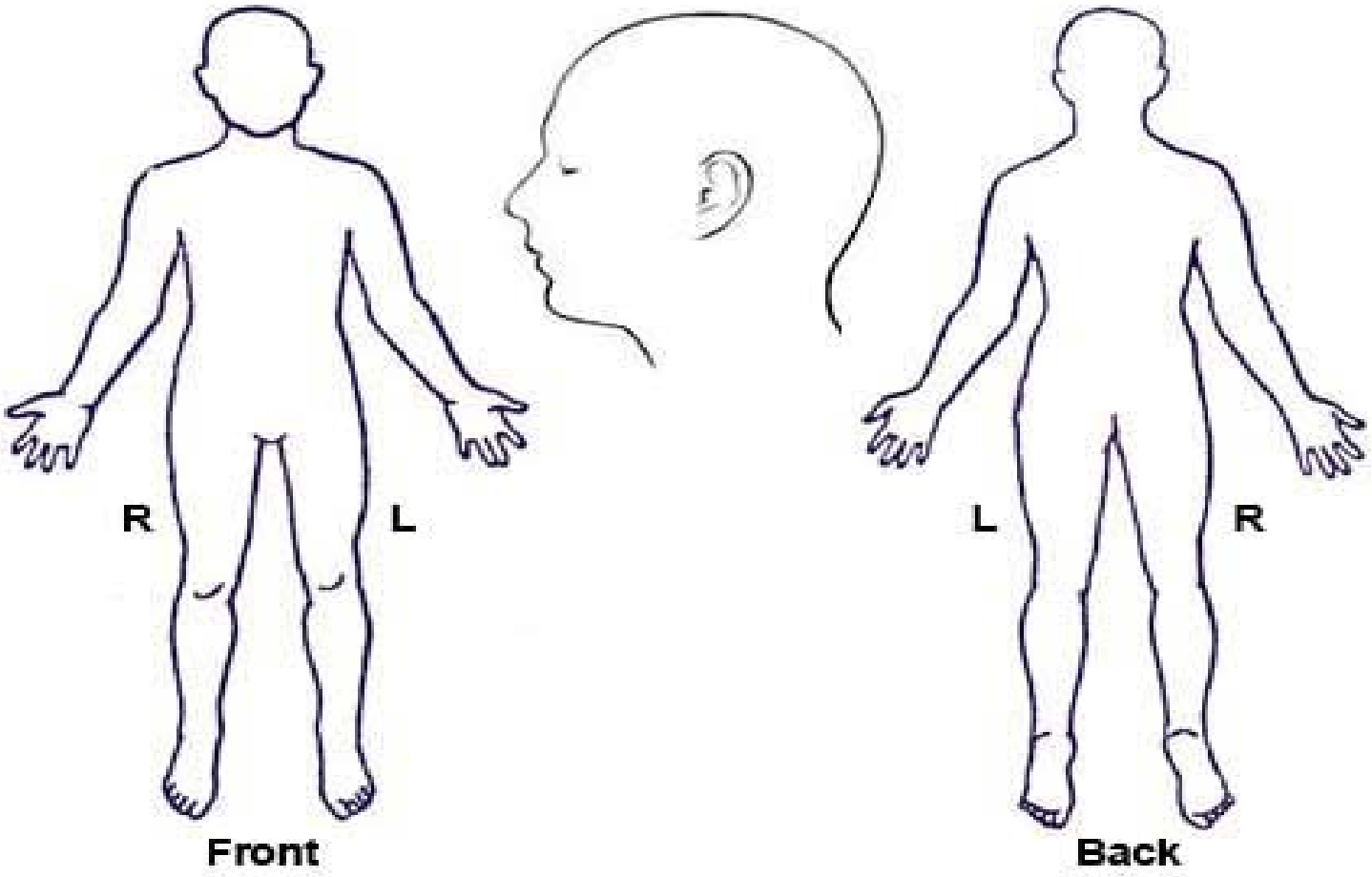
Describe any home treatment and the result: _____

Has the problem interrupted your sleep? _____

Does anyone in your family have a similar condition? Who? _____

Please list any additional complaints:_____

Please mark your area of pain on the diagrams below.



Please indicate your pain level now by placing an "X" on the line below:

_____

No Pain **Severe Pain**

Name: _____ Date: _____

Please check all of the following that apply to you:

❑ None (below conditions) apply:

Yes	No	Condition	Yes	No	Condition
❑	❑	History of recent infection	❑	❑	Prostate Problems
❑	❑	Recent fever	❑	❑	Frequent urination
❑	❑	HIV/AIDS	❑	❑	Pregnancy, # of births: _____
❑	❑	Aortic aneurysm	❑	❑	Urinary retention
❑	❑	Diabetes	❑	❑	Unexpected weight: ❑ Gain ❑ Loss
❑	❑	Corticosteroid use	❑	❑	Epilepsy/Seizures
❑	❑	Birth control pills	❑	❑	Visual disturbances
❑	❑	Stroke (date): _____	❑	❑	History of neck pain
❑	❑	Dizziness/Fainting	❑	❑	Arthritis
❑	❑	Numbness in groin/buttocks	❑	❑	Osteoporosis
❑	❑	Cancer/Tumor - Type _____			
❑	❑	Recent trauma			

Smoking Status? ❑ Yes Year Started? _____ ❑ Former Smoker? - Year Stopped_____
❑ Never Smoked

Alcohol Intake? ❑ No ❑ 1-2 time weekly ❑ 3-4 times weekly ❑ 5-7 times weekly

Do you exercise? ❑ No ❑ 1-2 time weekly ❑ 3-4 times weekly ❑ 5-7 times weekly

Type of exercise? _____

Other Health Information:
List any operations that you've had and the approximate dates:

1. _____ Date: _____ Doctor: _____

2. _____ Date: _____ Doctor: _____

3. _____ Date: _____ Doctor: _____

Are you taking any medications?

1. _____ For: _____

2. _____ For: _____

3. _____ For: _____

Medication Allergies? _____

Are you pregnant? ❑ No ❑ Yes Number of Weeks?_____ Due Date? _____

Please list any immediate family members (parents/siblings) who have or have had the following:

Cancer: _____ What kind of cancer? _____

Diabetes: _____

High blood pressure: _____

Cardiovascular disease: _____