

Patient Questionnaire – Non-Accident



Patient Name: _____

Today's Date: ___/___/___

Date of Exam: ___/___/___

Provider: _____

New Patient Yes No

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___

Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

| Name | Type of Licensure | Date of Last Visit |
|-------|-------------------|--------------------|
| _____ | _____ | ___/___/___ |
| _____ | _____ | ___/___/___ |

Please check any of the following symptoms you are now experiencing:

- | | | | | | |
|--|--|--|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Chest pain/rib pain | <input type="checkbox"/> Pain in arms/hands | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Loss of strength - arms | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sharp/shooting pain | |

Other _____

Have you experienced changes to:

- Eyes (sight) Ears (hearing) Nose (smell) Mouth (taste) Bladder
 Bowels Sleep Emotion Appetite

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ / /

2) _____ / /

3) _____ / /

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

- Heart Disease Diabetes Cancer Stroke High Blood Pressure Thyroid Problems
 Tuberculosis Prostate Disorder Kidney Problems Asthma Ulcer Seizure Disorder

Other: _____