PATIENT CONDITION QUESTIONAIRRE

NAME: ______________________________ DATE OF BIRTH: _______________________

REASON FOR VISIT: ____

____

WHEN DID YOUR SYMPTOMS APPEAR? ____

WHAT WERE YOU DOING WHEN YOUR SYMPTOMS APPEARED? ________________________

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IS YOUR CONDITION GETTING PROGRESSIVELY WORSE? Y N

WHAT TREATMENT HAVE YOU RECEIVED FOR YOUR CONDITION?

Medications: _______________ Surgery: _____________ Physical Therapy: ____________

Chiropractic: ______________ Other: ____

NAME OF OTHER PHYSICIANS WHO HAVE TREATED YOU FOR THIS CONDITION: ___________

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RATE YOUR PAIN:

Least Pain 1 2 3 4 5 6 7 8 9 10 Severe pain

TYPE OF PAIN: Persistent Intermittent

Sharp	Dull	Throbbing	Numbness	Aching
Shooting	Burning	Tingling	Cramps	Stiffness
Swelling	Other _______________________			

HOW OFTEN DO YOU HAVE THIS PAIN? ____

ACTIVITIES THAT ARE PAINFUL TO PERFORM:

Sitting Standing Walking Bending Lying Down

IS YOUR CONDITION DUE TO AN ACCIDENT? Y N

DATE OF ACCIDENT: _____________ ATTORNEY NAME (OPTIONAL): _______________________

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? : _____________________________