NEW PATIENT HEALTH QUESTIONAIRE

Explain **HOW** and **WHEN** it happened: ____

Please describe complaints below: (i.e. low back, shoulder, neck)

1. Involving head/neck: ____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
The pain is aggravated by: ____

The pain is relieved by: ____

2. Involving Mid Back/Shoulders/Arms & hands: ____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
The pain is aggravated by: ____

The pain is relieved by: ____

3. Involving Lower Back/Hips/Legs & Feet: ____
Frequency: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
The pain is aggravated by: ____

The pain is relieved by: ____

Symptoms have persisted for: ❒ _____ Hours ❒ ______ Days ❒ _____ Weeks ❒ _____ Months ❒ _____ Years
Are your symptoms/condition: ❒ Improving ❒ unchanged ❒ getting worse
Have you seen another physician for these conditions? ____
If Yes, Physician name & tests performed:

____
Have you had x-rays or other tests performed for this condition? □ No □ Yes What / When

____
Indicate your ability to perform the following activities: **U=Unable, P=Painful, D=Difficult, L=Limited, N=Normal**

______ Coughing or sneezing
______ Turning over in bed
______ Sitting at a table
______ Getting dressed
______ Driving a car
______ Getting in or out of a car
______ Walking short distances
______ Lying on back
______ Sleeping
______ Reaching
_______ Bending forward to brush teeth
_______Prolonged standing
_______Lifting up to 15 lbs
_______Pushing/Pulling
_______ Sexual activity

MEDICAL HISTORY:

What MEDICATION are you presently taking and for what condition? ______________________________
Have you ever been diagnosed with Cancer? ❒ No ❒ Yes Describe: ______________________________

CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

❒ Buzzing or ringing in ears
❒ Loss of bowel or bladder function
❒ Stomach difficulty/abdominal px
❒ Confusion/loss of Memory
❒ Frequent urination or painful
❒ Difficulty swallowing
❒ Unexplained weight loss/gain
❒ Heart Diseases
❒ Numbness/Tingling
❒ Blurring vision
❒ Loss of sleep
❒ History of Stroke
❒ Constipation
❒ Cancer
❒ Allergies
❒ Current Fever
❒ Fainting
❒ Headaches: Area of head: ________________________
How often: ❒ _____times/day ❒ _____times/week ❒ ______times/month
❒ Rectal bleeding
❒ Dizziness
❒ Chest pain
❒ Depression
❒ Diarrhea
❒ Asthma
❒ Aids/HIV
❒ Arthritis

Do you have a pacemaker? ❒ Yes ❒ No Do you have any metal implants ❒ Yes ❒ No

Please list any serious illness or medical conditions you have had and associated treatment:

____

____

WORK HISTORY:

How many hours do you normally work in a week? ______________ Are you currently not working? ❒ Yes ❒ No

In a typical workday, I: (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

Does your job require physical labor? If yes, please describe: ____

SOCIAL HISTORY:

Do you smoke? ❒ No ❒ Yes If yes, Packs per day ___________________________

Do you drink caffeine? __________ ❒ No ❒ Yes: if yes, cups per day ___________________________

Do you consume alcohol? ❒ No ❒ Yes; if yes, drinks per week __________________________________

Exercise: ❒ Light ❒ Moderate ❒ Heavy/Intense ❒ None

FAMILY HISTORY: Please list any family history of heart disease, cancer, diabetes or other serious illness:

Father: ______________________ Mother: _____________________Siblings: ____________________________

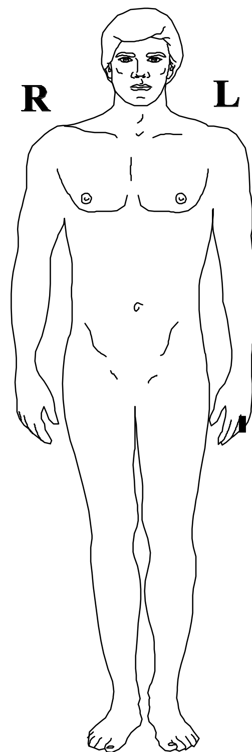
Woman Only: Are you pregnant? ❒ Yes ❒ No Date of last menstrual cycle: __________________________

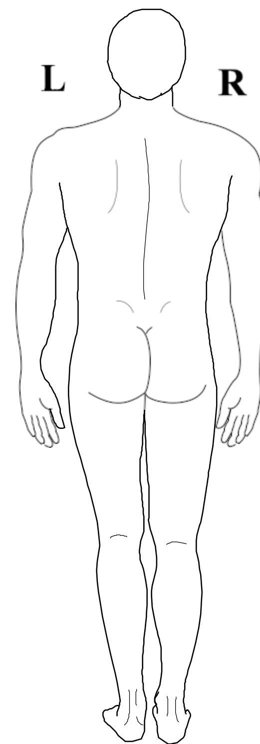
Men Only: Last Prostate exam: ____________________________ results: ________________________________

PAIN DIAGRAM

Use these symbols to describe the type of pain or sensations you are feeling:

***	**Stiffness**
>>>	**Aching pain**
///	**Stabbing or Sharp**
XXX	**Burning pain**
===	**Numbness**
ooo	**Pins and Needles**





Patient's Name: ______________________**Patient's Signature:** _________________________**Date:** ____/___ /_____

(Or guardian if child)