MEDICAL QUESTIONAIRE

NAME: ____ DATE: ________________________

Referring Physician: _____________________________________ Family Physician: __________________________

Reason for visit ____

How did your injury occur ____

Part(s) of body affected: ____

1. Have you had similar problems in the past? _____ Yes ________ No

2. Approximately when did this episode of pain start? ____
http://www.bocajava.com/atomic/
3. What were you doing when your symptoms started? ____

_____ Unsure ____ Sitting ____ Bending ____ Lifting ____ Walking ____ Sports ____ Accident ____ Other

4. Please explain where your pain first started: ______Unknown _____ Lower Back _____ Upper Back _____Low Back
______Low Back & One Leg _____ Low Back & Both Legs _____ Leg or Legs Only _____ Neck _____ Neck & One Arm
______Neck & Both Arms _____ Arm or Arms Only ____ Other

5. How has your pain changed since it started? _____ Improving _____ No change _____ Worse in One or Both Legs
_____ Worse in Back

6. What activities worsen your condition? ____

7. What relieves your condition? ____

PAST TREATMENT/EVALUATION OF YOUR CURRENT PROBLEM

Physical Therapy _____ Yes _____ No Ice Therapy ___ Yes _____ No Heat Treatment _____ Yes _____ No
Cortisone injection _____ Yes ____No Traction ____ Yes ____ No TENS Unit ____ Yes ____ No
Back Support ____ Yes ____ No Chiropractic Care ____ Yes ____ No Acupuncture ____ Yes ____ No
Home or Water Exercises ____ Yes ____No Epidural Injections ____ Yes ____ No Blood Tests ____ Yes ____ No
Medications _____ Yes ____ No
X-Rays ____ Yes ____ No If Yes Do you have them or reports with you _____Yes ____No
CAT Scan ____ Yes ____ No
MRI ______ Yes ________ No
EMG/Nerve Study ________ Yes ________ No

If Yes name of physician or facility: ____ Ph# _______________________

If you have had spinal surgery, indicate what type: ____
When________________ Month/Year __________ Surgeon: ____
Hospital: ____

MEDICAL HISTORY

Allergies: ____

MEDICAL QUESTIONAIRE

Medications:____

Do you have a history of the following?

Yes No Cancer (Location) ___________________________________
(Type) ____

- Yes No Diabetes
- Yes No High Blood Pressure
- Yes No Heart Disease
- Yes No Mitral valve prolapse
- Yes No Phlebitis
- Yes No Liver Disease
- Yes No Peptic Ulcers
- Yes No Anemia
- Yes No HIV or AIDS
- Yes No Kidney Disease
- Yes No Asthma
- Yes No Epilepsy
- Yes No Glaucoma
- Yes No Thyroid Disease
- Yes No Arthritis
- Yes No Polio
- Yes No History of Blood Transfusions
- Yes No Any Family History of Current Problems

Experience any of the following symptoms?

____ Fever
___ Fatigue
____ Double Vision
____ Hearing Problems
____ Shortness of Breath
____ Chest Pain
____ Varicose Veins
____ Ankle Swelling
____ Abdominal Pain
____ Frequent Bladder Infections
____ Skin Changes/rashes
____ Migrane Headaches
____ Insomnia
____ Vertigo
____ Anxiety Requiring Medication
____ Swollen Glands
____ Frequent Bruising

List any past surgeries (include dates): ____
____
____

SOCIAL HISTORY

Occupation: _____ Active _____ Retired

Primary Language: ______________________________________

Alcohol use: _____None _____ Rare _____ Social _____ Frequent

Smoking history: ______ Nonsmoker

Current smoker 1/4 pack per day 1/2 pack per day packs per day

Previous smoker (How long ago did you quit) ____

Any other information we should know about your health or current illness? _______________________________________
____
____