

## Medical Questionnaire Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

Other Physicians who care for you: \_\_\_\_\_

**List Medical Problems:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List Surgeries:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Medications/allergies listed by nurse in chart

<b>On a scale of 0-10, what is your pain today?</b>										
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
No Pain										Worst Pain Ever

What makes it feel better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Have you had X-rays/MRI/CT Scan for this? **Yes**  **No**

Have you ever had cancer? **Yes**  **No**

Have you ever had spine surgery? **Yes**  **No**

Have you seen a Chiropractor or D.O. for this? **Yes**  **No**

Have you tried Physical Therapy? **Yes**  **No**

Do you smoke? **Yes**  **No**

If yes, how much per day? \_\_\_\_\_

Do you consume alcohol? **Yes**  **No**

If yes, how much per day? \_\_\_\_\_

Do you consume caffeine? **Yes**  **No**

If yes, how much per day? \_\_\_\_\_

**Why are you here today?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**How long have you had this problem?** \_\_\_\_\_

\_\_\_\_\_

**If injured, when, exactly, did the injury occur?**

\_\_\_\_\_  
\_\_\_\_\_

**Mark location and type of discomfort:**

Use symbols below:

Burning: **XXX** Numbness: **OOO** Pins & Needles: **###**

Stabbing pain: **///** Ache: **VVV**

