PATIENT QUESTIONNAIRE

Name___________________________________________________________

Who referred you to this office? _____________________________________________

Who is your Primary Care Doctor? _____________________________________________

What are you being seen for today? □ LEFT □ RIGHT
□ NECK □ FOREARM □ LOW BACK □ CALF
□ SHOULDER □ WRIST □ HIP □ ANKLE
□ ELBOW □ HAND □ THIGH □ FOOT
□ FINGER □ KNEE □ TOE

Date you injured yourself: _____________________________________________

How did you injure yourself? _____________________________________________

Do you suffer from any of the following conditions?
□ THYROID DISEASE □ HYPERTENSION □ DIABETES □ ULCER
□ BLEEDING DISORDER □ HEART DISEASE □ EMPHYSEMA □ HEPATITIS
□ KIDNEY DISEASE □ HEART ATTACK □ ASTHMA □ GOUT
□ HEART MURMUR □ HEARTBURN □ BLOOD CLOTS □ MIGRAINE
□ HIGH CHOLESTEROL □ SEIZURES □ DEPRESSION □ CANCER
OTHER___________________________________________________________

Which medications are you currently taking?
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

Do you have allergies to any medications? _____________________________

What surgeries have you had in the past?
_______________________________________________________________
_______________________________________________________________

Do you smoke? __________ How much? __________ For how long? ______
Do you drink alcohol? ______ How much? ______ How often? ______
Are you Right or Left Handed? ______ Height__________ Weight__________