

Care Medical Center

2804 C. North Oak Street

Valdosta, GA 31602

(229) 241-8925

Patient Questionnaire

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

E-Mail Address: _____ Referred By: _____

Social Security #: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Sex: Male / Female

Chief Complaint: _____

| <u>Location:</u> | <u>Quality:</u> | <u>Time of Day:</u> | <u>Modifying Factors:</u> | |
|-----------------------------------|---|---------------------------------------|--------------------------------------|--------------------------|
| Head <input type="checkbox"/> | Achy <input type="checkbox"/> | Morning <input type="checkbox"/> | Increase | Decrease |
| Neck <input type="checkbox"/> | Dull <input type="checkbox"/> | Afternoon <input type="checkbox"/> | Standing <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder <input type="checkbox"/> | Sharp <input type="checkbox"/> | Evening <input type="checkbox"/> | Sitting <input type="checkbox"/> | <input type="checkbox"/> |
| Arm <input type="checkbox"/> | Stabbing <input type="checkbox"/> | Bedtime <input type="checkbox"/> | Walking <input type="checkbox"/> | <input type="checkbox"/> |
| Back <input type="checkbox"/> | Throbbing <input type="checkbox"/> | All The Time <input type="checkbox"/> | Climbing <input type="checkbox"/> | <input type="checkbox"/> |
| Thorax <input type="checkbox"/> | Radiating <input type="checkbox"/> | Varies <input type="checkbox"/> | Bending <input type="checkbox"/> | <input type="checkbox"/> |
| Elbow <input type="checkbox"/> | Burning <input type="checkbox"/> | | Squatting <input type="checkbox"/> | <input type="checkbox"/> |
| Wrist <input type="checkbox"/> | Itching <input type="checkbox"/> | | Sleeping <input type="checkbox"/> | <input type="checkbox"/> |
| Hip <input type="checkbox"/> | Numb <input type="checkbox"/> | | Up Stairs <input type="checkbox"/> | <input type="checkbox"/> |
| Knee <input type="checkbox"/> | Pins & Needles <input type="checkbox"/> | | Down Stairs <input type="checkbox"/> | <input type="checkbox"/> |
| Ankle <input type="checkbox"/> | | | Driving <input type="checkbox"/> | <input type="checkbox"/> |
| Foot <input type="checkbox"/> | | | Coughing <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Touch <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Sneezing <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Movement <input type="checkbox"/> | <input type="checkbox"/> |

| <u>Neurological Signs & Symptoms:</u> | <u>Numerical Pain Scale:</u> |
|--|--|
| Bowel Dysfunction <input type="checkbox"/> | 0 1 2 3 4 5 6 7 8 9 10 |
| Bladder Dysfunction <input type="checkbox"/> | |
| Motor Loss <input type="checkbox"/> | |
| Sensory Loss <input type="checkbox"/> | |
| Radiation to Arm <input type="checkbox"/> | |
| Radiation to Leg <input type="checkbox"/> | |
| | No Pain Worst Possible Pain |

| <u>Medications:</u> | <u>Dosage:</u> | <u>Allergies:</u> | <u>Primary Care Physician:</u> |
|---------------------|----------------|-------------------|--------------------------------|
| 1. _____ | 1. _____ | 1. _____ | Name: _____ |
| 2. _____ | 2. _____ | 2. _____ | Address: _____ |
| 3. _____ | 3. _____ | 3. _____ | _____ |
| 4. _____ | 4. _____ | 4. _____ | Phone: _____ |
| 5. _____ | 5. _____ | 5. _____ | |

| <u>Family History:</u> | <u>Social History:</u> | <u>Medical History:</u> | <u>Surgical History:</u> |
|--|---|--|--|
| Heart Disease <input type="checkbox"/> | Marital Status: | <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> |
| High Blood Pressure <input type="checkbox"/> | Single <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Appendectomy <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Married <input type="checkbox"/> | Hypertension <input type="checkbox"/> | Tonsillectomy <input type="checkbox"/> |
| Cancer (Type: _____) <input type="checkbox"/> | Separated <input type="checkbox"/> | Thyroid <input type="checkbox"/> | Inguinal Hernia <input type="checkbox"/> |
| Tuberculosis <input type="checkbox"/> | Divorced <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Ventral Hernia <input type="checkbox"/> |
| Bleeding Tendency <input type="checkbox"/> | Widowed <input type="checkbox"/> | Stroke <input type="checkbox"/> | Umbilical Hernia <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Alcohol: | GI Disorder <input type="checkbox"/> | Cholecystectomy <input type="checkbox"/> |
| Arthritis (Type: _____) <input type="checkbox"/> | Never <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Hysterectomy <input type="checkbox"/> |
| | 0 - 1 / week <input type="checkbox"/> | HIV <input type="checkbox"/> | Cesarean Section <input type="checkbox"/> |
| | 1 - 5 / week <input type="checkbox"/> | Kidney Disorder <input type="checkbox"/> | CABG <input type="checkbox"/> |
| | Other: _____ <input type="checkbox"/> | Cancer <input type="checkbox"/> | Coronary Stent <input type="checkbox"/> |
| | | Ulcer <input type="checkbox"/> | Carotid <input type="checkbox"/> |
| | Tobacco: | Seizure <input type="checkbox"/> | Endarterectomy <input type="checkbox"/> |
| | Never <input type="checkbox"/> | Asthma <input type="checkbox"/> | Angioplasty <input type="checkbox"/> |
| | Quit When? _____ <input type="checkbox"/> | Mental Illness <input type="checkbox"/> | Vascular Bypass <input type="checkbox"/> |
| | Packs per day _____ | Infections <input type="checkbox"/> | Craniotomy <input type="checkbox"/> |
| | Years smoked _____ | Anemia <input type="checkbox"/> | Total Hip <input type="checkbox"/> |
| | | Pregnancy <input type="checkbox"/> | Total Knee <input type="checkbox"/> |
| | Illegal Drugs? Y N | Other: _____ <input type="checkbox"/> | Rotator Cuff <input type="checkbox"/> |
| | Occupation: _____ | | Carpal Tunnel Release <input type="checkbox"/> |
| | | | Adverse RXN <input type="checkbox"/> |
| | | | Anesthesia <input type="checkbox"/> |
| | | | Lumbar <input type="checkbox"/> |
| | | | Laminectomy <input type="checkbox"/> |
| | | | Cervical Fusion <input type="checkbox"/> |
| | | | Arthroscopy <input type="checkbox"/> |
| | | | Ganglion <input type="checkbox"/> |
| | | | Mastectomy <input type="checkbox"/> |
| | | | Prostatectomy <input type="checkbox"/> |

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS

Doctor's Name: _____ Dates Treated: _____

Doctor's Name: _____ Dates Treated: _____

Doctor's Name: _____ Dates Treated: _____

Diagnosis: _____

X-rays & Dates: _____

Medication(s) Prescribed: _____

MRI (date & body region): _____

Physical Therapy Dates: _____

Other Tests & Dates: _____