SPEARS INJURY CLINIC

NEW PATIENT QUESTIONNAIRE

GENERAL INFORMATION:

Date ____________

Name ______________________________ Male Female (circle one) E-mail ______________

Address ______________________________ Home phone ______________

City ______________________ State _____ Zip Code _________ Cell phone ______________

Date of Birth ____________ Social Security # ________________ Work phone ______________

Employer ______________________________ Occupation ______________

Address ______________________ City ______________ State _____ Zip Code ____________

DESCRIPTION OF INJURY:

1. What was the date of your injury? ____________
2. Is your injury the result of an: ❑ auto accident ❑ work injury ❑ other

Please explain ____

____

____

3. Have you seen a chiropractor, medical doctor or been to a hospital regarding your injury? ________ If yes, whom did you see? ______________________

What treatment, if any, did they do ______________________________

____

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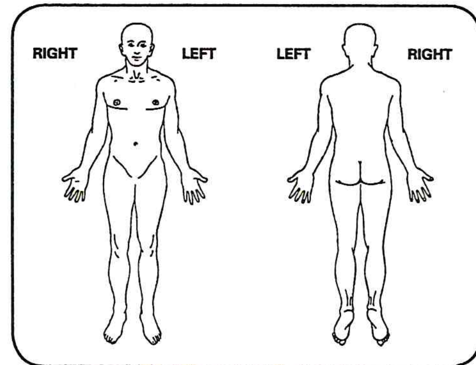
4. Using the diagram, please mark the areas of your pain.



5. Describe the character of your symptoms: (mark all that apply)

❑ burning ❑ tingling ❑ numbness ❑ dull

❑ stabbing ❑ shooting ❑ radiating

6. Since your symptoms began have they: ❑ improved ❑ worsened ❑ stayed the same
7. Are your symptoms: ❑ constant ❑ intermittent
8. Circle the items that you have tried to relieve your symptoms,

❑ bedrest ❑ ice ❑ heat ❑ over the counter pain meds ❑ prescription pain meds

❑ elevation ❑ bracing ❑ stretching ❑ massage ❑ Icy Hot/Ben Gay

❑ other please explain ______________________________

Over for second side

9. What daily activities aggravate your symptoms?

- ❑ walking up stairs ❑ driving ❑ lifting children ❑ house cleaning ❑ yard work
- ❑ take out trash ❑ stress & anxiety ❑ grocery shopping ❑ working ❑ standing
- ❑ sitting ❑ recreational activities ❑ other explain ______________________________

____

10. Is your sleep disturbed by these symptoms? ❑ Yes ❑ No

MEDICAL / SOCIAL HISTORY

1. Have your or any of your family members suffered from any of the following?

I Have	Family Member Has	Not in my family		I Have	Family Member Has	Not in my family	
❑	❑	❑	**Allergies**	❑	❑	❑	**Epilepsy**
❑	❑	❑	**Alcohol Dependence**	❑	❑	❑	**Fatigue**
❑	❑	❑	**Anemia**	❑	❑	❑	**Heart Attack / Disease**
❑	❑	❑	**Arteriosclerosis**	❑	❑	❑	**High Blood Pressure**
❑	❑	❑	**Arthritis**	❑	❑	❑	**HIV Infection**
❑	❑	❑	**Back Surgery**	❑	❑	❑	**Kidney Disease**
❑	❑	❑	**Broken Bones**	❑	❑	❑	**Low Blood Pressure**
❑	❑	❑	**Cancer**	❑	❑	❑	**Migraines**
❑	❑	❑	**Depression**	❑	❑	❑	**Motion Sickness**
❑	❑	❑	**Diabetes**	❑	❑	❑	**Multiple Sclerosis**
❑	❑	❑	**Dizziness / Fainting**	❑	❑	❑	**Polio**
❑	❑	❑	**Double or Blurred Vision**	❑	❑	❑	**Rheumatic Fever**
❑	❑	❑	**Drug Dependence**	❑	❑	❑	**Stroke**
❑	❑	❑	**Ear Infection**	❑	❑	❑	**TMJ**

Please explain, if necessary.____

____

2. If you have any condition / disease not listed above, please explain.______________________________

____

3. Do you smoke? ❑ Yes ❑ No If yes, how often?______________________

4. Do you drink alcohol? ❑ Yes ❑ No If yes, how often?______________________

5. Do you drink caffeinated beverages? ❑ Yes ❑ No If yes, how often?______________________

6. Please list all medications that you are presently taking. ______________________________

7. Please list all surgeries that you have had. ______________________________

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WOMEN ONLY:

1. Are you pregnant or think you may be pregnant? ❑ Yes ❑ No
2. Please list the date of you last menstrual period. ____________________

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Date ____________________

Patient's signature ______________________________