

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

Patient Name _____ Birth Date ____/____/____ Sex M F

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____ Social Security # _____

Marital Status: M S D W Family Physician: _____ Phone: _____

Describe your current complaint(s) and how it began: _____

Date the problem began: ____/____/____ or Gradual Onset Chronic/Recurrent

How much of the day are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Difficulty in: Standing Sitting Bending Walking Sleeping _____

How many times in the past year have you had similar discomfort? Never 1-2 3 or more

Please list any X-ray, MRI, CT, EMG, etc. taken of your complaint area within the past year:

1. _____ Where _____
2. _____ Where _____
3. _____ Where _____

List any doctors or therapists that you have seen for this complaint: _____

List any surgeries, the approximate dates, and the performing physician:

1. _____ Date: ____/____/____ Dr. _____
2. _____ Date: ____/____/____ Dr. _____
3. _____ Date: ____/____/____ Dr. _____

List any medications you are taking, why you are taking it, and which physician prescribed it:

1. _____ Dr. _____
2. _____ Dr. _____
3. _____ Dr. _____

List any pain relieving medications taken in the past twelve hours? _____

I attest that the above information is true and correct to the best of my knowledge.

Patient (or parent) signature: _____ **Date** ____/____/____