

Name:
 DOB:
 Chart:
 Age:
 Date:



DR. PAUL QUESTIONNAIRE

Name: _____ Acct #: _____ Date of Visit: _____
 Primary Care Physician: _____ Referring Physician: _____
 Phone Number: _____ Phone Number: _____

Reason for Visit today: _____

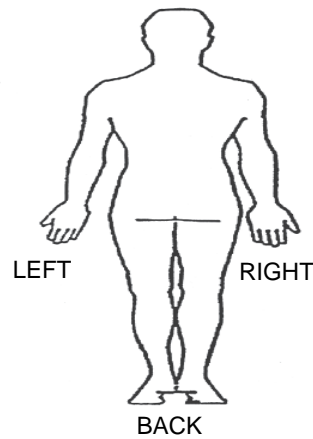
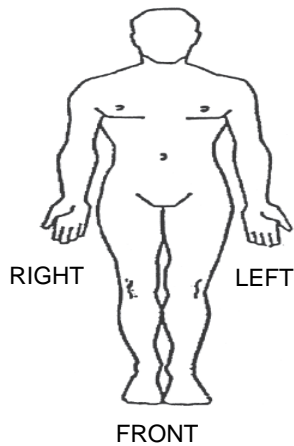
Where is the problem? <input type="checkbox"/> back <input type="checkbox"/> buttock <input type="checkbox"/> legs <input type="checkbox"/> neck <input type="checkbox"/> arms <input type="checkbox"/> hands <input type="checkbox"/> other _____	What caused it? <input type="checkbox"/> don't know <input type="checkbox"/> lifting something heavy <input type="checkbox"/> long drive/flight <input type="checkbox"/> car accident <input type="checkbox"/> fall <input type="checkbox"/> other _____	What does it feel like? <input type="checkbox"/> numbness <input type="checkbox"/> sharp/stabbing <input type="checkbox"/> dull ache <input type="checkbox"/> pins/needles <input type="checkbox"/> burning <input type="checkbox"/> cramping <input type="checkbox"/> other _____	Do you also have any of the following? <input type="checkbox"/> loss of strength <input type="checkbox"/> clumsy hands <input type="checkbox"/> trouble walking <input type="checkbox"/> frequent falls <input type="checkbox"/> problems with urination or bowels <input type="checkbox"/> fever/chills <input type="checkbox"/> can't get to sleep <input type="checkbox"/> pain wakes me up from sleep
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How long has this been present? _____ days _____ weeks _____ months _____ years

Please rate your pain from 0 (none) to 10 (worst pain): 0 1 2 3 4 5 6 7 8 9 10

Mark the areas on your body where you feel the described sensation. Use the appropriate symbol.

Numbness = = = = Stabbing / / / / Aches ▲▲▲ Pins & Needles ○○○○ Burning x x x x Cramping + + + +



Which side is worse? Left Right Both equal

Which is worse? Leg pain Back pain Both are equal

Arm pain Neck pain Both are equal

What makes it better? <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> bending <input type="checkbox"/> driving <input type="checkbox"/> other _____	What makes it worse? <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> bending <input type="checkbox"/> driving <input type="checkbox"/> other _____	What medications have you taken for it? <input type="checkbox"/> narcotics <input type="checkbox"/> anti-inflammatories <input type="checkbox"/> steroids <input type="checkbox"/> muscle relaxant <input type="checkbox"/> other _____	What therapies have you done for it? <input type="checkbox"/> chiropractor <input type="checkbox"/> physical therapist <input type="checkbox"/> injections <input type="checkbox"/> brace <input type="checkbox"/> other _____
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How long can you walk? _____ minutes _____ hours No limit

How long can you sit? _____ minutes _____ hours No limit

How long can you stand? _____ minutes _____ hours No limit

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TREATMENT

What imaging studies have you had done? X-rays CT MRI Other _____
Who have you seen for it? _____
Did you have surgery previously on the neck or back? Yes No

Please list:

Surgery _____ Date _____
Surgeon _____
Surgery _____ Date _____
Surgeon _____
Surgery _____ Date _____
Surgeon _____

MEDICAL HISTORY

Please list your medical problems:
 Heart: _____ Lung: _____ Kidney: _____
 Gastrointestinal: _____ Other: _____

SURGICAL HISTORY

Please list any other surgeries you have had: _____

MEDICATIONS

Do you have a blood clotting disorder or take blood thinners? Yes No

Please list your medications:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Do you have allergies to medications: Yes No If yes, please list: _____

FAMILY HISTORY

Has anyone in your family (blood relation only) have/had any of the following? CHECK ALL THAT APPLY:

High Blood Pressure Diabetes Arthritis Heart Disease Coronary Artery Disease
 Cancer Osteoporosis Seizures Thyroid Disorder Neurologic and/psychiatric disorders
Other _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you use tobacco products? Yes No if yes, how long? _____

If you are a former smoker when did you quit? _____

Do you consume alcoholic beverages? Yes No if yes, ___ # daily ___ # weekly ___ # monthly ___ socially

Are you currently employed? Yes No if yes, what is your occupation? _____

Are you disabled? Yes No if yes, how long and why? _____

Are you retired? Yes No if yes, from what capacity? _____

Is this a work related injury? Yes No if yes, please list when the injury occurred, as well as a brief description of the incident? _____

Was this injury caused from a motor accident? Yes No

If yes, please list when the injury occurred, as well as a brief description of the incident: _____

Did you have a happy childhood? Yes No Who do you live with? _____

Height _____ " Weight _____ lbs

Race: _____ Ethnicity: Hispanic Origin Non Hispanic Origin Preferred Language: _____

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REVIEW OF SYSTEMS Please check if you have any of the following:

SKIN

- Skin Rashes
- Abnormal Lumps
- Psoriasis
- Easy Bruising
- Painful Breasts
- Other

EYES

- Corrective Lenses
- Visual Loss
- Cataracts
- Glaucoma
- Double Vision
- Other

EARS

- Decreased Hearing
- Ringing in the Ears
- Other

THROAT

- Sore Throat
- Hoarseness
- Snoring

NOSE

- Sinus Problems
- Breathing Problems
- Other

CARDIOVASCULAR

- High Blood Pressure
- Low Blood Pressure
- Palpitations
- Irregular Heart Beat
- Heart Murmurs
- Rheumatic Fever
- Chest Pain

RESPIRATORY

- Shortness of Breath
- Mucus Production
- COPD
- Wheezing, Cough
- Chronic Bronchitis
- Asthma
- Emphysema

GASTROINTESTINAL

- GERD/Reflux
- Loss of Bowel Control
- Weight Loss
- Abdominal Pain
- Nausea/Vomiting
- Diarrhea
- Constipation
- Ulcer
- Hiatal Hernia
- Barrett's Esophagus
- Blood in Stools

MUSCULOSKELETAL

- Osteoarthritis
- Osteoporosis
- Fractures/Sprains
- Rheumatoid Arthritis
- Fibromyalgia
- Joint Swelling
- Gout
- Other

GENITOURINARY

- Blood in Urine
- Painful Urination
- Kidney Stones
- Urinary Frequency
- Loss of Bladder Control
- Benign Prostatic
- Hypertrophy/BPH
- Other

ENDOCRINE

- Enlarged Thyroid/Goiter
- Under Active Thyroid
- Excessive Appetite
- Excessive Thirst
- Overactive Thyroid
- Diabetes Mellitus

Notes:
