Name:
DOB:
Chart:
Age:
Date:

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DR. ATANDA QUESTIONNAIRE

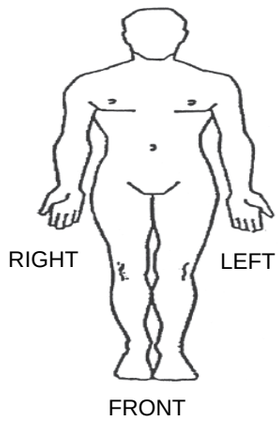
Name: _____ Acct #: _____ Date of Visit: _____
Primary Care Physician: _____ Referring Physician: _____
Phone Number: _____ Phone Number: _____

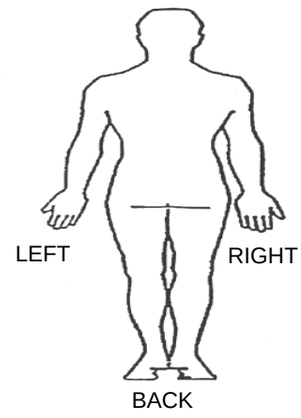
Reason for Visit today: _____

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

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?	What makes it worse?	What medications have you taken for it?	What therapies have you done for it?
☐ sitting	☐ sitting	☐ narcotics	☐ chiropractor
☐ standing	☐ standing	☐ anti-inflammatories	☐ physical therapist
☐ bending	☐ bending	☐ steroids	☐ injections
☐ driving	☐ driving	☐ muscle relaxant	☐ brace
☐ other _____	☐ other _____	☐ other _____	☐ other _____

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: _____

Name:
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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

NOSE
- ☐ Sinus Problems
- ☐ Breathing Problems
- ☐ Other

THROAT
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Snoring

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

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Mucus Protection
- ☐ 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: _____