Patient Questionnaire

Date: 07/31/2026

First Name:_____ Last Name:_____ Age:_____

Date of Birth:_____ M F SSN:_____

Phone: _____ Alternate Number:_____

Email Address:_____ Marital Status: M___S___D___W___

Race: _____ Ethnicity: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Patient Employer: _____ Phone: _____

Primary Insurance:_____ ID: _____ Group: _____

Primary Policy Holder Details

Name: _____ DOB:_____ SSN:_____ Relationship to Patient:_____

Employer:_____

Secondary Insurance:_____ ID: _____ Group: _____

Secondary Policy Holder Details

Name: _____ DOB:_____ SSN:_____ Relationship to Patient:_____

Employer:_____

Reason for Today's Visit:_____

Is this a work-related injury? Y N

If you are here for spinal issues, have you had the following for those issued (check all that apply)?

Physical Therapy - If yes, when and how long? _____

Spinal Injections - If yes, when and how many? _____

Chiropractor - If yes, when and how long? _____

Pain Medicine - If yes, when, by whom and how long? _____

Medication List

Please list your medications and dosages (include vitamins/supplements)

Medication Name	Strength	# of Capsules	Times per Day

*If you have additional meds list them on the back of this page

Pharmacy Name:_____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Allergies

Allergies to Medication:

Are you allergic to latex? Y N

Social History

Have you ever smoked? Y N

Please fill in the chart below

	Present	Past	Age at start	How many per day?
Tobacco (Smoking / Chewing)				
Alcohol				
Other Substances (marijuana, cocaine, heroine, etc)				
Caffeinated Foods (tea, chocolate, coffee)				

Medical History

Have you had or do you currently have any of the following medical issues (check all that apply)

	You	Mom	Dad	Siblings
Diabetes				
Heart Disease				
High Blood Pressure				
COPD				
Tremors				
Autoimmune Disease				
Bleeding Problems				
Seizures				
Serious Head Injury				
Stroke				
Stomach Ulcers				
Aneurysm				
Hepatitis				
Thyroid				
HIV/AIDS				
Multiple Sclerosis				
Parkinson's				
Back/Neck Injury				
Cancer: Type				

Please list any other medical problems:

Surgical History

Procedure	Date of Procedure

*If you have additional surgeries list them on the back of this page

Pain Details

How is the pain affecting your daily living? _____

What makes pain better or worse? _____

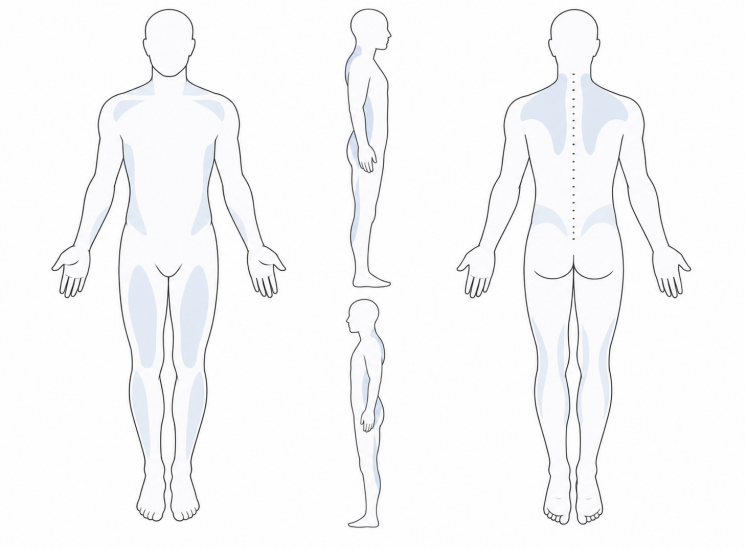
What aggravates the symptoms? _____

Location of Pain? _____

Severity of Pain on a 1-10 scale? _____

Duration of Pain? _____

Is Pain?



Mark an X where Pain is located

Symptoms

Have you been feeling ANY of the following symptoms (check all that apply)

Chills	Fainting spells	Excessive thirst
Fevers	Depression	Feel too cold frequently
Weight change	Rash	Feel too hot frequently
Blood transfusion	Back pains	Anemia
Swallowing	Joint pains	Swollen glands
Double vision	Neck pains	Bleeding problems
Blurred vision	Shooting arm pain	Hay fever
Loss of vision	Shooting leg pain	Environmental allergies
Wheezing	Loss of consciousness	Anaphylaxis
Shortness of breath	Dizziness	Increased urinary frequency
Frequent cough	Memory loss	Painful urination
Chest pain	Hearing loss	Urinary retention
Heart palpitations	Sleeping problems	