New Patient Questionnaire Form

Date:__________  Occupation:_________________  Are you currently working?______

1. Please rate your pain from 0 to 10 for the condition that brings you to our facility today. 
   “0” means “no pain”, “10” means “Emergency Room” pain: _____________________
   (Please indicate the location of your pain on the diagram on the back of this form)

2. When did the problem start?___________________________________________________

3. Was there an injury?                             Yes      No

4. Have you had X-rays or other tests done?       Yes      No
   If yes, what were the results?____________

5. Have you had surgery for this condition?       Yes      No
   If yes, date and type of surgery:__________

6. Have you fallen in the last 2 months?          Yes      No

7. Please list current medical conditions/problems and any previous surgeries:____________
   ____________________________________________________________________________
   ____________________________________________________________________________

8. What medications are you currently taking?______________________
   ____________________________________________________________________________
   ____________________________________________________________________________

9. Please list any allergies:__________________________
   ____________________________________________________________________________

10. Please check the appropriate box concerning your ability to perform the following activities:

    Getting in/out of a car  Able  Difficult  Need Assistance  Unable
    Getting up out of a chair
    Sitting up from a lying position
    Getting in/out of shower/tub
    Shaving/brushing teeth
    Grooming hair
    Getting dressed

11. How did you hear about us?
   □ MD Office
   □ Print ad, billboard, radio
   □ CAMC Website (www.camc.org)
   □ Internet search engine (Google, Yahoo, etc)
   □ Friend/Family Member
   □ Other: ________________________________________________________________
Because violence is so common in many people’s lives and results in serious health problems, I ask all my patients about it:

12. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?______ If yes, would you be willing to talk about it?______