FACT FINDING

CONFIDENTIAL Patient Questionnaire

Personal Information

Name _____ Date _____

Patient Signature _____ Phone (Home) _____

Email _____ Cell Phone _____

Age _____ Date of Birth _____ Phone (Work) _____ Ext. # _____

Address _____ City _____ State _____ Zip _____

Marital Status ☐ M ☐ S ☐ D No. of Children _____ Social Security No. _____

Occupation _____ Employer Name _____

Employer Address _____

Name of Spouse _____ Employer of Spouse _____

Name of Nearest Relative _____ Phone _____

Financial & Insurance Information

Name of party responsible for payment _____

Social Security No. _____ Driver's License No. _____

Do you have insurance ? ☐ No ☐ Yes _____
Company

Employee I.D. No. _____

_____
Patient's Insurance | Policy No. | Group Plan No. | Medicare No.

_____
Spouse's Insurance | Policy No. | Group Plan No. | Medicare No.

_____
Workers' Compensation Carrier | Other

Current Complaint Section

Describe Complaint: _____

_____

_____

_____

At the time of this current complaint, were you under any medically prescribed disabilities or self imposed restrictions? ☐ No ☐ Yes (Describe) _____

_____

_____

Other Medical Care

List any other doctors seen for this condition (include address).

Dr. Name Address

Dr. Name Address

Dr. Name Address

Did you go to the hospital? ☐ Yes ☐ No

If yes, how did you get to hospital? ☐ Ambulance ☐ Other _____

If admitted to hospital, how long did you stay? _____

What type of treatment did you receive? (Include recommendation, x-ray etc.) _____

Any medication prescribed? ☐ No ☐ Yes List name _____

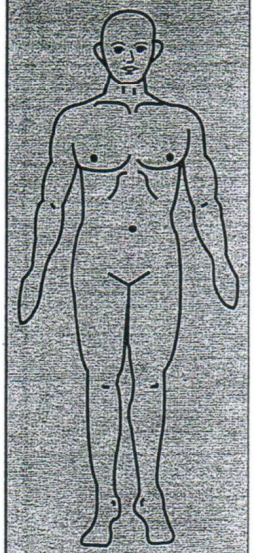
General Health History

- ☐ Cancer
- ☐ Tuberculosis
- ☐ Hypertension
- ☐ Diabetes
- ☐ Arthritis
- ☐ Migraine
- ☐ Sinus History
- ☐ Asthma
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Dizziness
- ☐ Convulsions
- ☐ Concussion
- ☐ Allergies
- ☐ Heart Attack
- ☐ Polio
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Digestive Problems
- ☐ Numbness
- ☐ Tingling
- ☐ Anemia
- ☐ Back Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Venereal Disease
- ☐ Neuritis
- ☐ Rheumatism
- ☐ Psoriasis

If female, are you pregnant?
☐ Yes ☐ No

☐ Any prior hospitalization or surgery? (list) _____

Present Complaints



- ☐ Headache
- ☐ Concentration Loss
- ☐ Eyes Sensitive to Light
- ☐ Memory Loss
- ☐ Heavy Feeling of Head
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Pain Behind Eyes
- ☐ Intolerance to Alcohol
- ☐ Fainting
- ☐ Palpitation
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Motion Restricted
- ☐ Upper Back Pain/Stiff
- ☐ Mid Back Pain/Stiff
- ☐ Low Back Pain/Stiff
- ☐ Right/Left Shoulder Pain
- ☐ Right/Left Arm Pain
- ☐ Low Back Pain
- ☐ Right/Left Leg Pain
- ☐ Pins & Needles arms/legs
- ☐ Vision Problems
- ☐ Sinus Trouble
- ☐ Nervousness
- ☐ Chest Pain
- ☐ Short of Breath
- ☐ Irritable
- ☐ Numbness (_____ Where)
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Fatigue
- ☐ Flushed Face
- ☐ Pale Face
- ☐ Excess Perspiration
- ☐ Neuritis
- ☐ Constipation
- ☐ Digestive Trouble
- ☐ Nausea
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Swelling (_____ Where)
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Loss of Consciousness
- ☐ Cuts (_____)
- ☐ Bleeding (_____)
- ☐ Broken Bones (_____)
- ☐ Bruises (_____)
- ☐ Jaw Pain
- ☐ Other (_____)
- ☐ Other (_____)

☐ Radiation of Pain Into ☐ Rt. Arm ☐ Rt. Leg ☐ Left Arm ☐ Left Leg ☐ Both ☐ Both

☐ Aggravation of Pain Upon ☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Riding

Pre-Existing Conditions

Have you sought care for a health condition in the past year? ☐ Yes ☐ No Past 2 years ☐ Yes ☐ No

If yes, what condition? _____

Was treatment administered? ☐ No ☐ Yes Describe: _____

_____

Do you take medication? ☐ No ☐ Yes Describe: _____

_____

_____

COMPLETE THIS SECTION IF DUE TO ACCIDENT

Accident History (Auto Section)

Type of accident ☐ Auto ☐ Worker's Compensation ☐ Fall ☐ Other _____

Date of accident _____

Brief description of accident. _____

_____

_____

IF AUTO ACCIDENT COMPLETE BELOW

Did vehicle have seatbelts? ☐ Yes ☐ No

Were seatbelts worn? ☐ No ☐ Yes ☐ Shoulder ☐ Lap

List (seat) position in vehicle: _____

If vehicle had headrests, describe the position compared to your head

- ☐ Top of headrest aligned with top of head
- ☐ Top of headrest aligned with middle of head
- ☐ Top of headrest aligned with bottom of head

Briefly describe the impact collision.

☐ Head on Collision ☐ Left Side Impact ☐ Right Side Impact ☐ Rear End Collision

List any parts of your body that made contact with vehicle parts. _____

_____

Were you braced for impact? ☐ Yes ☐ No

Were brakes applied? ☐ Yes ☐ No

Were you looking up into inside rear view mirror? ☐ Yes ☐ No

Were you looking at outside door mirror? ☐ Left ☐ Right

Was your car stopped? ☐ Yes ☐ No

Any previous motor vehicle accidents? ☐ No ☐ Yes Describe: _____
(include date)

_____

_____

If yes, was treatment rendered previously? ☐ No ☐ Yes Describe: _____
(include date and Dr's name)

_____

_____

_____