Laser Spine and Pain Institute

Health Questionnaire

PATIENT INFORMATION

Date:_______________

Patient Name:___________________________________ Date of Birth:___________________________

Height:____ Weight:_______________________________

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

____

____

____

List any surgeries or hospitalizations you have had, complete with the month and year for each:

____

____

____

List anything you are allergic to:____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation of you to the individual):

____

____

____

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Do you exercise? ___Yes ___No Hours per week:________________ What activity(s)?_______________

____

Are you dieting? ___Yes ___No Since:_______ Do you smoke? ___Yes ___No _____packs per day.

How many years have you been smoking?_________

Do you drink alcoholic beverages? ___Yes ___No ______ drinks per day

Do you wear (please circle if yes): Heal Lifts Arch Supports Prescription Orthotics

For women: Are you pregnant or nursing? ___Yes ___No If pregnant, how many weeks?_____________

Date of last menstrual period:____

MEDICAL HISTORY

Describe the reason(s) for your doctor visit today:

____

____

____

____

Are you here because of an accident? ___Yes ___No What type?________________________________

When did your symptoms start?_________________ How did your symptoms begin?_______________

____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms (Circle all that apply) Sharp Dull Ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting Better Staying the Same Getting Worse

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How do your symptoms interfere with your work or normal activities? ___________________________

____

____

Have you experienced these symptoms in the past?____

____

____

HISTORY OF TREATMENT

Primary care physician:___________________________________ Phone:_________________________

Date last seen:________________________ May we update them on your condition? ___Yes ___No

Have you seen a chiropractor before? ___Yes ___No Who referred you to us? _____________________

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

____

____

____

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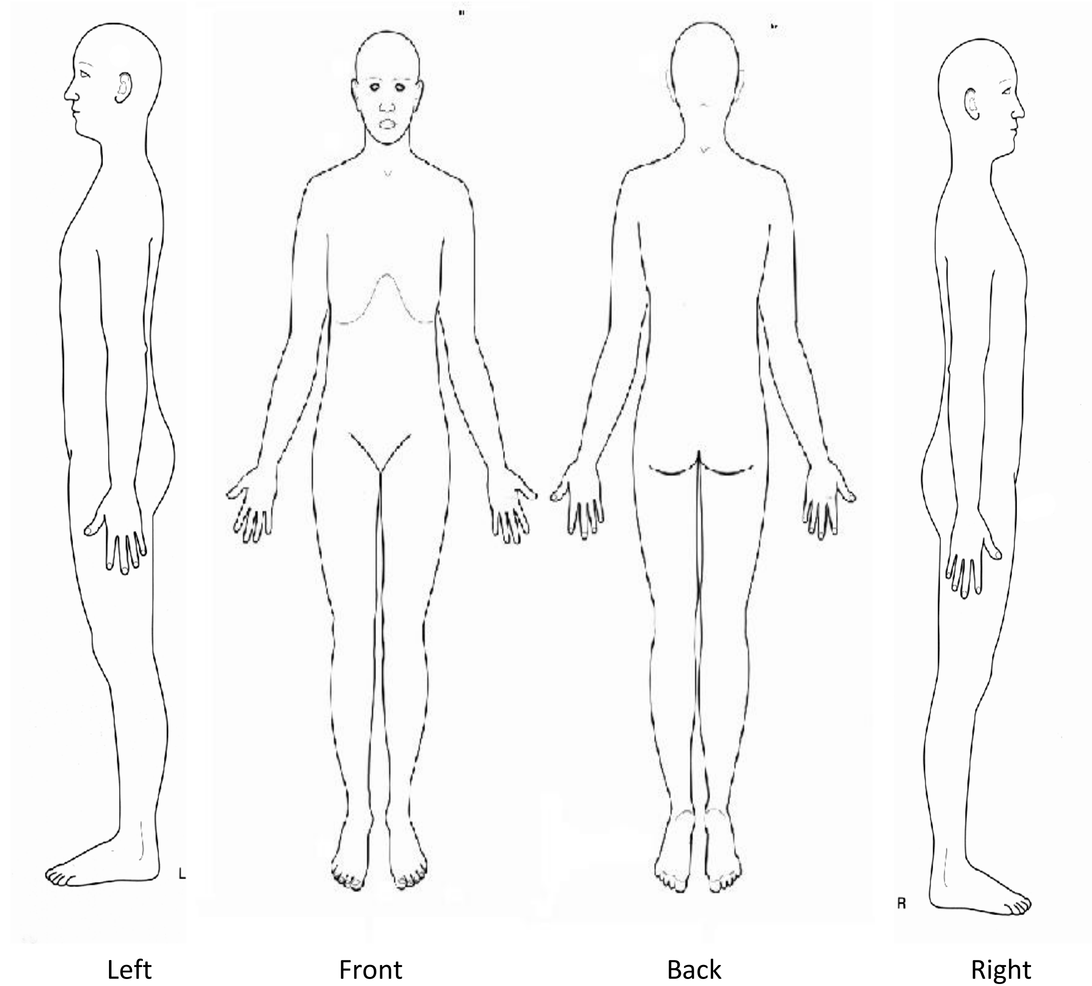
DESCRIPTION OF CONDITION

Mark any area(s) of discomfort with the following key:

A = Ache N = Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Front Back Right

On a scale of one to ten, how intense are your symptoms?

Not Intense 0 1 2 3 4 5 6 7 8 9 10 Unbearable

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Condition	Past	Present	Condition	Past	Present
Abdominal pain	O	O	Elbow/upper arm pain	O	O
Abnormal weight gain/loss	O	O	Epilepsy	O	O
Allergies headache	O	O	Frequent urination	O	O
Angina	O	O	General fatigue	O	O
Ankle/foot pain	O	O	Hand pain	O	O
Arthritis	O	O	Heart attack	O	O
Asthma	O	O	Hepatitis	O	O
Bladder Infection	O	O	High blood pressure	O	O
Birth control pills	O	O	Excessive thirst	O	O
Cancer	O	O	Hip/upper leg pain	O	O
Chest pains	O	O	HIV/AIDS	O	O
Chronic sinusitis	O	O	Hormone therapy	O	O
Depression	O	O	Jaw pain	O	O
Dermatitis/eczema	O	O	Joint swelling/stiffness	O	O
Dizziness	O	O	Kidney stones	O	O
Drug/alcohol use	O	O	Knee/lower leg pain	O	O
Liver/Gall Bladder Disorder	O	O	Loss of bladder control	O	O
Low back pain	O	O	Mid back pain	O	O
Neck pain	O	O	Painful urination	O	O
Prostate problems	O	O	Shoulder pain	O	O
Smoking/tobacco use	O	O	Stroke	O	O
Systematic lupus	O	O	Thoracic outlet syndrome	O	O
Tumor	O	O	Ulcer	O	O
Upper back pain	O	O	Wrist pain	O	O

Additional comments you would like the doctor to know:______________________________________

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____

____

Patient's signature:_______________________________ Doctor's signature:______________________

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