PATIENT QUESTIONAIRE

NAME_____ DOB_____AGE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME #_____CELL #_____ SEX: MALE FEMALE

OCCUPATION_____EMPLOYER_____WORK #_____

IN CASE OF EMERGENCY CONTACT

NAME_____ PHONE #_____RELATION_____

HOW DID YOU FIND OUT ABOUT US?_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

WHAT IS YOUR PRIMARY PROBLEM & WHEN DID IT OCCUR?_____

_____

IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT? YES NO COMP?

IS THIS A WORKMAN'S YES NO

LIST ANY SURGERIES YOU HAVE HAD_____

_____

_____

LIST ANY MAJOR ILLNESS/INJURY YOU HAVE HAD_____

_____

LIST ANY CURRENT MEDICATIONS_____

_____

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

_____SEVERE/FREQUENT HEADACHES

_____ARTHRITIS ___RHEUMATOID___OSTEO

_____HIGH/LOW BLOOD PRESSURE

_____LOSS OF SLEEP DUE TO CONDITION

_____HEART CONDITION:_____

_____SHORTNESS OF BREATH/FATIGUE

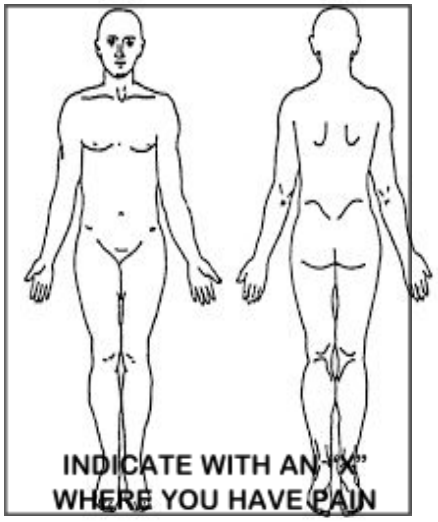
_____DIABETES

_____NEUROPATHY/SENSATION LOSS

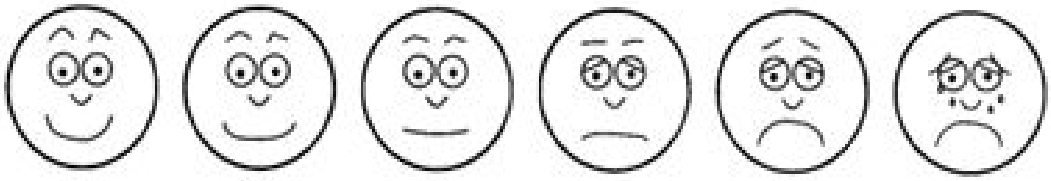
_____HIV

_____HEPATITIS

TOBACCO USE



INDICATE WITH AN "X" WHERE YOU HAVE PAIN



MEDICARE PATIENTS ONLY

HEIGHT_____WEIGHT_____

ARE YOU CURRENTLY RECEIVING ANY FORM OF HOME HEALTH SERVICES? YES NO

HAVE YOU HAD ANY FALLS IN THE LAST 12 MONTHS? YES NO

PATIENT SIGNATURE____**DATE**_____________________________