CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME OF PATIENT_____

Date of Accident/Injury or Onset of Complaint: _____
Was this (check one) ☐ **WORK RELATED ACCIDENT,** ☐ **SLIP AND FALL INJURY**
or ☐ **OTHER?**
What details can you provide about the accident/injury/complaint?

_____

_____

_____

_____

_____

Were you Hospitalized? ☐ Y/N ☐
Name of Hospital: _____
When? _____
Treatment Provided by The Hospital:

☐ Medication for Pain
☐ X-Rays
☐ Ice to Relieve Swelling
☐ Medication for Pain and Spasm
☐ CT Scan
☐ Emergency LifeSaving Procedures
☐ Other _____
☐ Medication for Spasm
☐ MRI
☐ Stitches

Since the time of the accident, has your condition
Not Changed Slightly Improved Significantly Worsened

What is your most important complaint (C.C.)?_____
_____

When did this complaint (C.C.) first begin?_____
_____

How did the C.C. begin:

- ☐ Gradually/slowly
  - ☐ Occasionally present
  - ☐ Constantly present
- ☐ Suddenly/quickly
  - ☐ Occasionally present
  - ☐ Constantly present

Pain level:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Gets worse with:

- ☐ Standing
- ☐ Bending
- ☐ Lifting
- ☐ Sneezing
- ☐ Coughing
- ☐ Twisting
- ☐ Lying Down
- ☐ Temperature

_____

- ☐ Nothing affects it
- ☐ Other activities and/or movements:

_____

Do you have any other health concerns?

_____

Gets better with:

- ☐ Rest
- ☐ Medication
- ☐ Walking
- ☐ Stretching
- ☐ Lying down
- ☐ Excersise
- ☐ Nothing affects it
- ☐ Other activities and/or movements:

_____

_____

Is the C.C. getting:

- ☐ Worse
- ☐ Better
- ☐ Staying the same

Do you have any other comments?

_____

_____

_____

Pain description:

- ☐ Achy
- ☐ Tingly
- ☐ Throbbing
- ☐ Spasm
- ☐ Numb
- ☐ Burning
- ☐ Other:

_____

Past Medical History

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ GERD
- ☐ Ulcer
- ☐ RA
- ☐ OA
- ☐ Hepatitis
- ☐ Depression
- ☐ Anxiety
- ☐ CORD
- ☐ TB
- ☐ Renel Disease
- ☐ Hepatic Desease
- ☐ Obesity
- ☐ Seizures
- ☐ High Cholesteral
- ☐ Contagious illness(es)
- ☐ Other:_____

_____

Past Surgical History:

- ☐ Gastric Bypass
- ☐ Heart Bypass
- ☐ Hernia Repair (inguinal)
- ☐ Hernia Repair (umbilical)

- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Cateract Surgery
- ☐ Cesarean
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Low Back Surgery
- ☐ Neck Surgery
- ☐ Tonsillectomy
- ☐ Other _____
  _____

Smoking/Tobacco:

- ☐ Heavy Smoker
- ☐ Light Smoker
- ☐ Chew Tobacco
- ☐ None
- ☐ Former Smoker

Drugs:

- ☐ Recreational Use
- ☐ None

Medical Alert:

- ☐ Addicted to Alchohol
- ☐ Diabetic
- ☐ Addicted to Drugs
- ☐ HIV
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other _____
  _____

Have you ever had any prior complaints to the affected region? ☐ Y/N ☐

_____

If yes, have you resolved the complaint so that it is non-contributory ? ☐ Y/N ☐

_____

Did the current complaint exist already and has become worse as a result of the injury in question?

_____

Habits

Alcohol:

- ☐ Heavy
- ☐ Social
- ☐ None
- ☐ Former Alcoholic

NAME	*CITY*	*DATE OF FIRST VISIT*	*REASON*	*UNDER CARE STILL?*
				☐ *Y/N* ☐
				☐ *Y/N* ☐
				☐ *Y/N* ☐
				☐ *Y/N* ☐

What other Medical Providers have you seen since the onset of the complaint/accident?