Patient Questionnaire

NAME: DATE:

Purpose of your visit: (please circle)

1. Spinal Check-up 2. Specific Problem

If Specific Problem-

1. What is your problem? _____

2. When did it start? _____

3. What caused it? _____

4. Have you had this before? (Please circle) YES NO

5. If yes – How often_____ When: _____

6. How would you best describe it? (Circle)

Sharp Pain Dull ache Sharp Shooting Tingling Numbness Throbbing Weakness

Spasm Stiffness Catching Pain Other _____

7. Have you seen anyone else for this problem?

Who? _____

When? _____

Diagnosis? _____

Length of therapy? _____

Type of therapy? _____

Outcome? _____

8. Does anything aggravate your problem?_____

Does anything relieve it? _____

9. Do you have any other health issues? _____

_____