NEW PATIENT QUESTIONNAIRE

Today's Date:_________________________

First Name: ________________________ Middle:________________________ Last:_____________________________

Age:_____________ Date of Birth____________________ Right handed_____ Left handed_____

Referring Physician:________________________________ Location:_______________________

Primary Care Physician:_____________________________ Location:_______________________

Chief Complaint

What is your main complaint or symptom that brought you to see us? ____

____

What makes it better or worse?____

____

Present Illness Do you have any of these problems?

	Headache		Nausea		Vomiting		Sleepiness
	Speech Problems		Numbness		Weakness		Walking Problems
	Bladder Problems		Bowel Problems		Pain		Seizures
	Hearing Loss		Dizziness		Tingling		

What doctors have treated you for this condition?____

____

Have you had any scans for this condition? YES_____ NO_____

If yes, what type? CT Scan_____ MRI_____ Other____

Any previous treatment for this condition? YES_____ NO_____

If yes, please list:____

Review of Systems Check if you have noticed any of the following:

	Fever		Fatigue		Weight Loss		Weight Gain
	Change in Appetite		Visual Changes		Seasonal Allergies		Shortness of Breath
	Chest Pain		Abdominal Pain		Diarrhea		Constipation
	Bloody/Tarry Stools		Loss of libido		Excessive hunger/thirst		Difficulty Urinating
	Easy Bruising		Easy Bleeding		Rash/Skin Condition		Muscle Aches or Pain
	Depression		Memory Problems		Spontaneous Nipple Discharge		Excessive hunger/thirst

Past Medical History Do you have any of these medical illnesses:

	Heart Disease		Asthma		Emphysema		Diabetes
	Thyroid		Cancer		High Blood Pressure		Ulcer
	Serious Injuries		Stroke		Kidney Problems		

Have you had any surgeries? YES_____ NO_____ If yes, please list:____

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Are you allergic to any medications, latex, or tape? YES_____ NO_____ If yes, please list:___________________

____

Brief Fatigue Inventory:

Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0	1	2	3	4	5	6	7	8	9	10
No Fatigue										As bad as you can imagine

Family History

Have any members of your family, such as grandparents, parents, or children, had any serious illnesses? If so, please list and include which family member has had the illness:

____

____

Social History

Are you: Single_____ Married_____

Are you: a Homemaker_______ Employed outside the home_______ Retired________ On Disability_______

If employed outside the home, what type of work?____

Do you smoke/chew? YES_____ NO_____ If yes, how much and for how long?___________________________

Do you consume alcohol? YES____ NO_____ If yes, how much? ____

Do you take any illicit drugs? YES ____ NO ____

Sensation Drawing

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

SYMPTOM =	Ache	Burning	Numbness	Pins & Needles	Stabbing
SYMBOL =	^^^^	xxxx	0000	////	====

How bad is your pain? (circle one)
On a scale of 0 to 10 (0 = no pain, 5 = moderate, 10 = worst pain)
At its very worst 0 1 2 3 4 5 6 7 8 9 10
Now 0 1 2 3 4 5 6 7 8 9 10

Name ____

Current Medications

Please list your current medications, vitamins and supplements. Please include the dosage, frequency taken and prescribing physician.

Medication	Dosage	Frequency	Prescribing physician

Additional Comments: