Momentum Medicine Plus

Medical Orthopedics|Sports Medicine|Pain|Osteopathic Manipulation

New Patient Questionnaire

Name:_____ **Date:**____/____/2014

Social Security #:_____-_____-_____ **Age**:_____ **Sex:** □Male □Female **DOB:**_____/_____/_____

Dominant Hand: □ Right □ Left **Are you currently working?**□No □Yes

If no, what was the last day you worked?:_____ Do you have light duty restrictions? □No □Yes:_____

If you were injured, where were you when this occurred or pain started? □Home □Work □Auto □Sport □Other:_____

Injury:□No □Yes, Date:_____ Auto Accident :□No □Yes, Date:_____ Auto Accident :□No □Yes, Date:_____

A. Major Complaint:

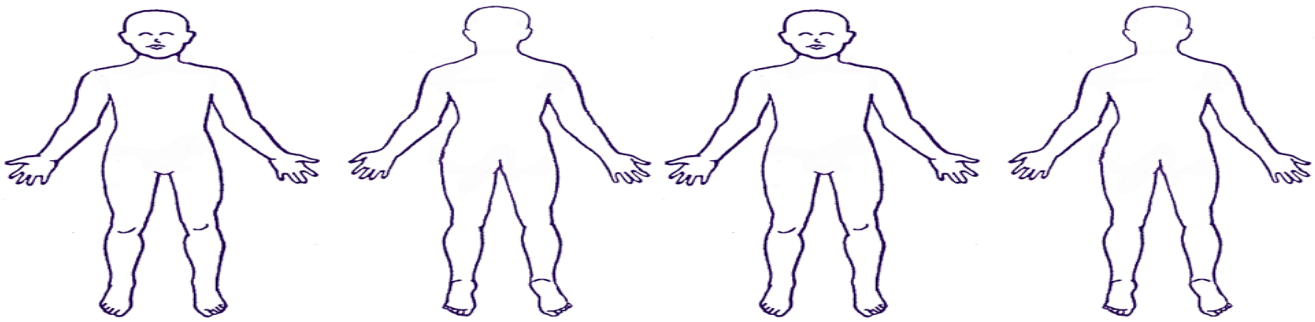
1. Describe the main reason for your visit today?_____
   _____
   _____
   _____
2. How does this condition affect you?_____
3. Do you have any of the following with this condition? □Pain □Numbness □Itching □Redness □Swelling □Burning Sensation □ Coldness □Warm □Other:_____
4. When did this condition begin?_____. Has this condition been diagnosed by a physician or other health care provider? □No □Yes. If yes , what was the diagnosis?_____
5. Are you currently being treated for this condition by anyone else? □No □Yes. If yes, who?_____
6. How was the above problem caused? □ No cause □Fall □Injury □Auto Accident □Other:_____
7. Who has treated you for this? □ Family Dr. □ Orthopedic Dr. □ Chiropractor □Pain Dr. □Neurologist □Acupuncturist □Naturopath □None □Other:_____
8. What tests have you had for this? □ Xrays □ MRI □ CT Scan □Ultrasound □ None □Other:_____
9. What treatment(s) have you had for this? □Pain Meds □ Epidural Injections □ Facet Blocks □ Steroid/cortisone Injections □Physical Therapy □Acupuncture. □ Chiropractic manipulation □ None □Other:_____
   _____
10. When did you start treatment for this?_____. Did this treatment help? □Yes □Somewhat □Not Much □Not at all
11. Did you have surgery for this? □No □Yes. If yes, what type?_____. Date : ____/____/___
12. Did this surgery help? □Yes □No. When did you last see a doctor for this?_____

B. 2nd Complaint (if any)

1. Describe the 2nd reason, if any, for your visit today?_____
   _____
   _____
   How does this condition affect you?_____
2. Do you have any of the following with this condition? □Pain □Numbness □Itching □Redness □Swelling □Burning Sensation □ Coldness □Warm □Other:_____
3. When did this condition begin?_____. Has this condition been diagnosed by a physician or other health care provider? □No □Yes. If yes , what was the diagnosis?_____
4. Are you currently being treated for this condition by anyone else? □No □Yes. If yes, who?_____
5. How was the above problem caused? □ No cause □Fall □Other:_____
6. Who has treated you for this? □ Family Dr. □ Orthopedic Dr. □ Chiropractor □Pain Dr. □Neurologist □Acupuncturist □Naturopath □None □Other:_____
7. What tests have you had for this? □ Xrays □ MRI □ CT Scan □Ultrasound □ None □Other:_____
8. What treatment(s) have you had for this? □Pain Meds □ Epidural Injections □ Facet Blocks □ Steroid/cortisone Injections □Physical Therapy □Acupuncture. □ Chiropractic manipulation □ None □Other:_____
   _____
9. When did you start treatment for this?_____. Did this treatment help? □Yes □Somewhat □Not Much □Not at all
10. Did you have surgery for this? □No □Yes. If yes, what type?_____. Date : ____/____/___

Did this surgery help? □Yes □No. When did you last see a doctor for this?_____

C. Answer ONLY if you have the following:
Mark an **X** where you have **pain** on the diagram: Circle where you have **numbness/tingling**:



1. What does you pain feel like? □Sharp □Throbbing □Burning □Aching □Stabbing □Sore □ Constant □Off and On □Other:_____
2. Does this pain radiate? □No □Yes. If yes, where?_____
3. What makes pain better? □Nothing □Ice □Heat □Rest □Movement □Pressure □Message □Other:_____
4. What makes pain worse? □Nothing □Ice □Heat □Rest □Movement □Pressure □Message □Other:_____
5. Does anything relieve the pain (example, medications, treatment)?_____

C. PAST MEDICAL HISTORY

Ears/Eye Problems: □ Nose Bleeds □□ Sinus Infections □□ Allergies □ Glaucoma □Cataracts

Gastrointestinal:□Ulcers □Hernia □Acid Reflux □Irritable Bowel Disease (IBS) □Liver □Hepatitis □Gastric Bypass

Genitourinary: □ Erectile Dysfunction □ Frequent UTI's □ Uterine Fibroids □ Bladder Problems □Blood in urine

Reproductive: □ Infertility □ Fibroids □ Uterine Cancer □ Pregnant □ Breastfeeding

Kidney: □ Kidney Failure □ Kidney Cysts □ Kidney Stones

Neurological:□ Headaches □ Migraines □ Seizures □ Brain Tumor □Concussion □ Stroke □ Neuropathy

Skin: □ Rashes □ Boils □ Acne □ Psoriatic Arthritis □ Blisters □ Cellulitis □ Bed Sores

Vascular/Hematological:□Anemia □Bleeding Problems □DVT/Blood Clots □Cancer □Leukemia □Varicose Veins

Heart: □ High Cholesterol □High blood Pressure □Low Blood Pressure □ Heart Arrhythmias □ Heart Attack □CHF(Heart Failure) □ Pacemaker □ Murmur □□Chest Pain/Angina □ Sleep Apnea

Lung/Pulmonary: □ Asthma □ COPD □ Sleep Apnea □ Bronchitis □ Lung Cancer

Endocrine: □ Diabetes □ Hypothyroidism □ Hyperthyroidism □ Obesity □ Overweight □ Excessive Sweating

Infectious Disease: □ HIV/AIDS □ Pneumonia □ STD's □ Tuberculosis □ MRSA □ Lyme Disease

Psychiatric:□Anxiety □Depression □Suicidal Ideation □Bipolar □Schizophrenia □ADHD □Alcoholism □Drug Abuse

D. REVIEW OF SYSTEMS: *Please check any symptoms you have*

General			***Cardiovascular***			***Musculoskeletal***		
Fever	Yes	No	Chest Pain	Yes	No	Swelling in Multiple Joints	Yes	No
Chills	Yes	No	Blood Clotting Problem	Yes	No	Excessive Flexibility of Joints	Yes	No
Weight Loss	Yes	No	Swelling in legs	Yes	No	Joint Pain	Yes	No
Weight Gain	Yes	No	High/ Low Blood Pressure	Yes	No			
Skin			**Pulmonary/Respiratory**			**Neurological**		
Skin Rash	Yes	No	Wheezing	Yes	No	Headaches	Yes	No
Boils	Yes	No	Frequent Cough	Yes	No	Weakness	Yes	No

Persistent Itch	Yes	No	Shortness of Breath	Yes	No	Numbness/Tingling	Yes	No
Sores	Yes	No				Dizziness	Yes	No
HEENT			**Genitourinary**			**Vascular/Hematologic**		
Hearing Loss	Yes	No	Kidney Stones	Yes	No	Easy Bruising	Yes	No
Vision Loss	Yes	No	Painful Urination	Yes	No	Blood Clots	Yes	No
Blurry Vision	Yes	No	Difficulty Urinating	Yes	No	Vein Problems	Yes	No
			Bloody Urinating	Yes	No	Anemia	Yes	No
			Vaginal Discharge	Yes	No			
Endocrine			**Gastrointestinal**			**Psychiatric**		
Excessive Thirst	Yes	No	Abdominal Pain	Yes	No	Severe Depression	Yes	No
Too Hot/Cold	Yes	No	Nausea/Vomiting	Yes	No	Anxiety	Yes	No
Tired/Sluggish	Yes	No	Indigestion/Heartburn	Yes	No	Bipolar	Yes	No

E. SURGICAL HISTORY & MEDICATIONS

Past Surgeries	Date of Surgery	Current Medications		
		Name of Medication	Dosage	Frequency

F. ALLERGIES: Are you allergic to Any Medications ☐No ☐Yes. If yes which ones?_____
_____ . Are you allergic to ☐Latex ☐Adhesive ☐ Iodine

G. FAMILY HISTORY

Family Member	Age	Alive?	Deceased?	**Illness or Cause of Death?** Diabetes, Heart disease, Strokem High Blood Pressure, High Cholesterol, Cancer, etc
Mother				
Father				
Brother(s)				
Sister(s)				
Son(s)				
Daughter (s)				

H. WORK HISTORY

Are you currently working? ☐ No ☐ Yes. If yes where and what type of job?_____
If not working, when did you last work?_____. **What type of work did you do?_____**

I. SOCIAL HISTORY:

☐ Single ☐Married ☐Divorced ☐Separated ☐ Widowed ☐Partner
Do you live alone? ☐Yes ☐No. If no, who do you live with? (spouse, child, family, friends)?_____.
How did you get to the office today? ☐ Drove a car yourself ☐ Someone else drove you here ☐ Bus ☐ Train
☐ Private Transportation ☐Other:_____.
Did you come to the examination today alone? ☐Yes ☐No. If no, who did you come with?_____
Do you smoke? ☐ No ☐ Yes. If yes, how many packs per day? ☐ 1 ☐ 2 ☐ 3
Do you drink ☐ No ☐ Yes. If yes, how many drinks? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 per ☐ day or ☐ week?
Do you use illegal drugs ☐ No ☐ Yes.

Patient Signature:_____ Date: _____/____/2014

Reviewed by Physician:_____ Date: _____/____/2014