

Confidential Patient Information

Name: _____ Date: ____/____/____

1. Rate the intensity/severity of your problem on a scale of 1 – 10 (10 being the worst): _____
2. When did your condition begin?: _____
3. Have you ever had this condition before? no yes
If yes, please explain: _____
4. How often does this condition bother you? (please circle): constant ____x/day ____x/week
other: _____
5. Is there anything that makes your condition better or worse? _____
Have you tried any self-treatment such as (please circle): ice heat exercise rest
6. Have you seen any other doctors for this condition? yes no
If yes, who? _____

What advice or treatment did they provide? _____

7. Have you missed any work as a result of your condition? yes no If yes, how much? _____
8. Has this condition interfered with any of the following? (please circle all that apply)
sleep immune system job
appetite recreation other: _____
energy level social life _____
9. Have you noticed any changes in your functional habits? (please circle all that apply)
appetite Bowel movements other: _____
urination menstrual cycle _____
10. Are you taking any medications? yes no If yes, what kind? _____

11. Do you have any prior history of illness, injuries, hospitalization, surgery, or medication usage that has any relation to your current condition? yes no
If yes, please explain: _____

12. How would you rate your general health? (please circle) bad poor good excellent
13. Do you smoke? yes no If yes, how much? _____
14. Do you drink alcohol? yes no If yes, how much? _____
15. Do you use any recreational drugs? yes no If yes, please explain: _____

Patient Name: _____
(please print)

Patient Signature: _____ Date: ____/____/____