OPTIMUM CARE THERAPY

PATIENT QUESTIONNAIRE:

Name: _____

Birth Date/Age: _____ / _____

Referring Physician: _____

Family Physician: _____

Emergency Contact Name: _____

Phone/Cell: _____

Occupation & Employer: _____

Gender: _____Pregnant: (yes or no) _____

Reason for your visit:_____

How did you obtain the injury?

_____

Are you currently working? _____If no, are you not able to work due to injury?_____

What are the physical demands of your job? _____

What are your household activities? _____

List any hobbies that you are unable to participate due to your injury? _____

Have you had surgery for this injury? _____Type of surgery/dates:_____

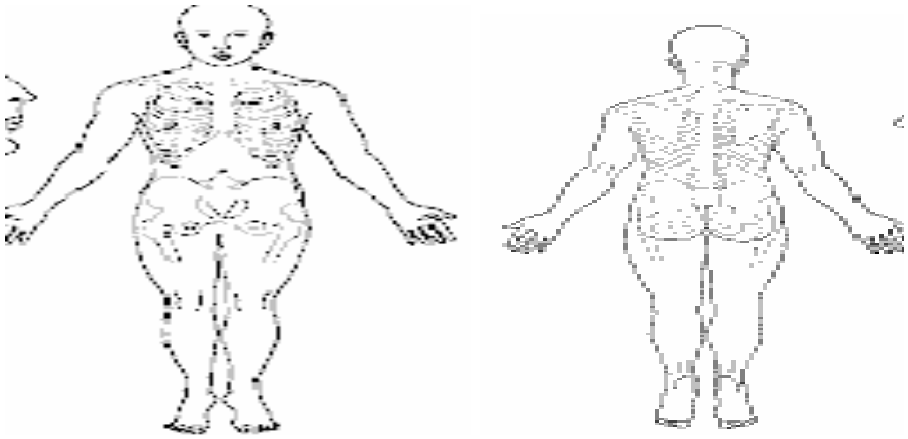
Are you currently taking any prescription or non-prescription medications? YES or NO

Please list all the medication that you are currently taking:

_____

PAIN QUESTIONNAIRE:

Please shade on the diagram below the location of your problem/pain.



Describe your pain

- € Sharp

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- € Dull
- € Aching
- € Shooting
- € Throbbing
- € Other _____
- € Is your pain
- € Constant
- € Intermittent

Pain Rating: Please rate your pain using the numeric scale listed below.
*A rating of **"0"**means you have no pain at all.
*A rating of **"10"** means that your pain is unbearable and you should go to the Emergency Room immediately.

PLEASE RATE YOUR PAIN AT THE PRESENT TIME:

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Very Painful		Intense Pain-Go to ER	

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode?

PREVIOUS MEDICAL CARE-*Yes or No*

Chiropractor ___ ___

General Practitioner ___ ___

Occupational Therapy ___ ___

Physical Therapy ___ ___

Massage Therapy ___ ___

Neurologist ___ ___

Orthopedist ___ ___

MEDICAL EXAM-*Yes or No*

CT Scan ___ ___

EMG/NCV ___ ___

MRI ___ ___

Myelogram ___ ___

X-Rays ___ ___

Emergency Room Care ___ ___

Podiatrist ___ ___

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Do you now have, or have you ever had, any of the following?

MEDICAL HISTORY-*YES or NO*

Asthma, Bronchitis, or Emphysema ___ ___

Shortness of Breath/Chest pain ___ ___

Coronary Heart Disease or Angina ___ ___

Do you have a Pacemaker ___ ___

High Blood Pressure ___ ___

Heart Attack/Surgery ___ ___

Blood clot/emboli ___ ___

Stroke/TIA ___ ___

Allergies ___ ___

Pins or Metal Implants ___ ___

Joint replacement (any) ___ ___

Diabetes ___ ___

Infectious diseases ___ ___

Cancer/Chemotherapy/Radiation ___ ___

Arthritis/Swollen joints ___ ___

MEDICAL SYMPTOMS-*YES OR NO*

Severe or Frequent Headaches ___ ___

Vision or Hearing difficulty ___ ___

Numbness or tingling ___ ___

Dizziness or Fainting ___ ___

Weakness ___ ___

Weight loss/Energy loss ___ ___

Hernia ___ ___

Epilepsy/Seizures ___ ___

Thyroid trouble/Goiter ___ ___

Incontinence ___ ___

Bowel or bladder problems ___ ___

Neck Injury/Surgery ___ ___

Shoulder Injury/Surgery ___ ___

Elbow/Hand Injury/Surgery ___ ___

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Back Injury/Surgery ___ ___

Osteoporosis ___ ___

Knee Injury/Surgery ___ ___

Sleeping problems/difficulty ___ ___

Leg/Ankle/Foot Injury/Surgery ___ ___

Do you smoke? ___ ___

Multiple Sclerosis ___ ___

Latex Sensitivity/Allergy ___ ___

Parkinson's Disease ___ ___

Additional comments:

_____

_____

FOR WOMEN ONLY: YES or NO

Pelvic Inflammatory disease ___ ___ Endometriosis ___ ___

Irregular Menstrual Cycle ___ ___ Incontinence (urinary/fecal) ___ ___

Complicated pregnancies/deliveries? ___ ___

Please check box and sign below:

Consent € I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered

Signature:_____ Date:_____