StraightBack
Solutions for Scoliosis

New Patient Questionnaire

Today's Date:

Last Name **Initial** **First Name**	**Home #**
Address	**Work #**
City / Postal Code	**Cell #**
Male Female / **Date of Birth (MM/DD/YY)**	**Email**
Name of spouse or significant other	**Employer**
Number of children	**Occupation**

Personal Health Number (Care Card)	Do you have private insurance?
Family Doctor	
How did you hear about our office?	Did someone refer you? If so, who?

Purpose of this Visit

Why are you here today?

When did today's problem start?

Has it gotten BETTER WORSE stayed the SAME

How often does this bother you?

What makes it better?

What makes it worse?

Height

Weight

Wt changed 10 lbs or more in the last year? Y / N

Please list any medications you take or surgeries you have had

Please list any dietary supplements you take

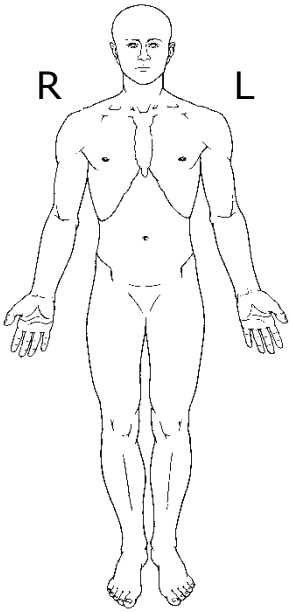
e.g. vitamins and minerals

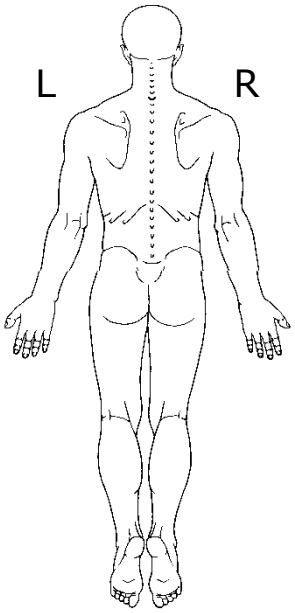
Please describe any accidents or other injuries you have had

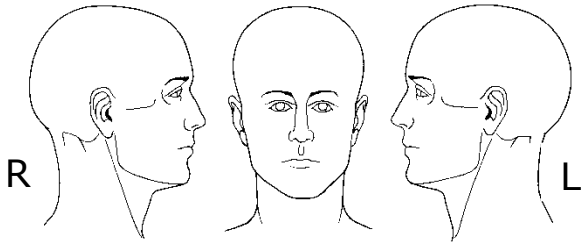
Please describe your exercise habits

Please draw the location of any symptoms you may have on the body outline below, using the appropriate symbol(s).

Ache	Burning	Numbness	Pins and Needles	Stabbing	Stiff and Tight	Shooting Pain
AAA	BBB	NNN	+++	///	222	→ → →







Please CHECK anything that applies to you now, or CIRCLE anything that applied in the past.

GENERAL:

- □ Cancer
- □ Unexplained weight change
- □ Stroke
- □ High blood pressure
- □ Diabetes
- □ Osteoporosis

NECK:

- □ Neck pain
- □ Stiff neck and shoulders
- □ Numbness or tingling in: shoulders, arms or hands
- □ Headaches
- □ Dizziness or balance problems
- □ Visual problems
- □ Weakness in grip
- □ Jaw problems
- □ Sinus problems
- □ Low energy or fatigue
- □ Thyroid problems

MID-BACK:

- □ Mid-back pain
- □ Heart problems
- □ Stomach problems
- □ Rib problems
- □ Difficulty or pain with breathing
- □ Indigestion or heartburn
- □ Lung problems
- □ Recurrent lung infections
- □ Asthma, allergies, or wheezing

LOW-BACK:

- □ Low-back pain
- □ Stiff low-back
- □ Numbness or tingling in: bum, legs, or feet
- □ Sciatica
- □ Muscle cramps in legs or feet
- □ Weakness in back or legs
- □ Constipation or diarrhea
- □ Painful or irregular menstrual cycle
- □ Sexual dysfunction
- □ Frequent or difficult urination

Have any of your BLOOD RELATIVES had any diseases or significant health concerns?
If so, please describe below. (M=Mother F=Father B= Brother S=Sister G=Grandparents)