

**CRESPO & ASSOCIATES, P.A.**  
**NEW PATIENT QUESTIONNAIRE**

Chart # \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 1** Please fill out or circle the appropriate areas. Please answer each question as completely as possible. If you do not understand any questions, please feel free to ask our staff.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Age: \_\_\_\_\_ Male / Female Left Handed / Right Handed Ethnicity: Hispanic/Latino Non-Hispanic/Latino  
Race: Please circle: Caucasian Black (Non-Hispanic) Hispanic Asian Native American Other \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**Please identify your injury** (check which one applies):

- Was your injury due to an auto accident?
- Were you a pedestrian?
- Were you riding a motorcycle / bicycle?
- Was it work related?
- Did you suffer from a slip and fall?
- Other: \_\_\_\_\_

How do you *best* learn?

By listening?  Yes  No

By reading?  Yes  No

By watching?  Yes  No

Briefly explain how the accident occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IF AUTO RELATED:**

- Were you the **driver** or the **passenger**? (circle one)
- Were you wearing your seatbelt? **YES / NO**
- Were you in the front seat? **YES / NO**
- Did the airbags deploy? **YES / NO**
- Did the police respond? **YES / NO**
- Was an accident report filled out? **YES / NO**

**FOR ALL INJURIES:**

- Did an ambulance respond? **YES / NO**
- Did you go to the hospital or emergency room? **YES / NO**
- Were you transported by ambulance? **YES / NO**
- Name of the hospital: \_\_\_\_\_

Were you admitted to the hospital or examined and released from E.R.? \_\_\_\_\_

In the Emergency Room, I was given: **Medication for pain** **Muscle relaxers** **Anti-inflammatories**  
**Neck brace** **Instructions** **X-rays** **CT Scan**  
**Other (please list):** \_\_\_\_\_

Because of this injury, I have had the following tests done:

X-rays **YES / NO** If yes, what part of the body was scanned and at what facility? \_\_\_\_\_

MRI **YES / NO** If yes, what part of the body was scanned and at what facility? \_\_\_\_\_

CT scan **YES / NO** If yes, what part of the body was scanned and at what facility? \_\_\_\_\_

Nerve tests **YES / NO** These are special tests performed with the aid of a computer. If so, please indicate what area of your body was tested and at what facility was the test performed? \_\_\_\_\_

Other tests **YES / NO** \_\_\_\_\_

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Have you seen any other doctors for this injury? **YES / NO**

If so, Doctor's Name \_\_\_\_\_

Name of Facility \_\_\_\_\_

Address of Facility \_\_\_\_\_ Phone: \_\_\_\_\_

This doctor was a **MD-medical / DO-osteopath / DC-chiropractor**.

Treatment began on or about (date): \_\_\_\_\_.

What was the treatment? \_\_\_\_\_

I am currently under the treatment of Dr. \_\_\_\_\_ in (city) \_\_\_\_\_

I receive treatment approximately \_\_\_\_\_ times per week.

Treatment currently includes: **manipulation / ice / heat / massage / ultrasound / traction / exercise**  
**other:** \_\_\_\_\_.

The current treatment is **helping very much / helping a little / not helping at all**.

Please use the following scale when answering the Questions in Section 2.



0	1	2	3	4	5	6	7	8	9	10
No Pain	Hardly notice pain	Notice pain, does not interfere with activity	Sometimes distracts me	Distracts me, can do usual activities	Interrupts some activities	Hard to ignore, avoid usual activities	It is focus of attention, prevents daily activities	Awful, hard to do anything	Can't bear the pain, unable to do anything	As bad as it can be, nothing else matters

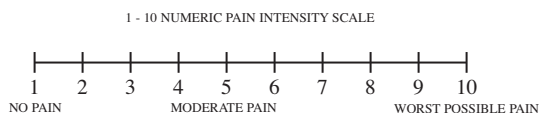
**SECTION 2** Please circle the difficulties or symptoms you are currently experiencing.

**\*\*\*Headaches** **YES / NO**

When did they begin? \_\_\_\_\_. Do you feel they are related to this accident? **YES / NO**

The pain is **always / comes and goes**. The quality of pain is **dull / sharp / burning / other** \_\_\_\_\_

Rate your pain



The pain is **greater on the left / greater on the right / equal on both sides**.

The pain is associated with **nausea / vomiting / dizziness / worse with bright lights**.

The pain seems to begin **at the base of the skull / over both eyes / over left eye / over right eye**.

Additional comments: \_\_\_\_\_  
\_\_\_\_\_

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Last Name \_\_\_\_\_

**\*\*\*Neck (Cervical) Pain YES / NO**

When did it begin? \_\_\_\_\_. Do you feel it is related to this accident? **YES / NO**

The pain is **always / comes and goes**. The quality of pain is **dull / sharp / burning / other** \_\_\_\_\_

1 - 10 NUMERIC PAIN INTENSITY SCALE



The pain is **greater on the left / greater on the right / equal on both sides**.

The pain **is / is not** associated with **pins & needles / numbness / pain** and radiates into my (name part of the body ie: arm, hand, etc.) \_\_\_\_\_.

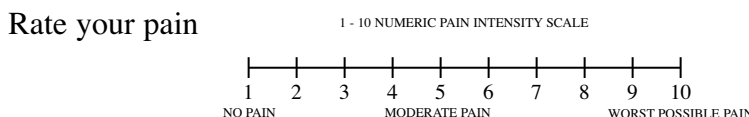
The pain is worse with **sneezing / lifting / coughing / bowel movements**.

Additional comments: \_\_\_\_\_

**\*\*\* Mid-back, between the shoulders (Thoracic) Pain YES / NO**

When did it begin? \_\_\_\_\_. Do you feel it is related to this accident? **YES / NO**

The pain is **always / comes and goes**. The quality of pain is **dull / sharp / burning / other** \_\_\_\_\_



The pain is **greater on the left / greater on the right / equal on both sides**.

Additional comments: \_\_\_\_\_

The pain is/is not associated with **pins & needles / numbness / pain** and radiates into my (name part of the body ie.: arm, hand, etc.) \_\_\_\_\_.

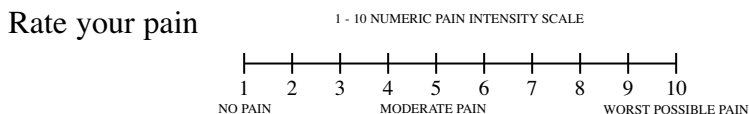
The pain is worse with sneezing / lifting / coughing / bowel movements.

Additional comments: \_\_\_\_\_

**\*\*\*Low Back (Lumbar) Pain YES / NO**

When did it begin? \_\_\_\_\_. Do you feel it is related to this accident? **YES / NO**

The pain is **always / comes and goes**. The quality of pain is **dull / sharp / burning / other** \_\_\_\_\_



The pain is **greater on the left / greater on the right / equal on both sides**.

The pain **is / is not** associated with **pins & needles / numbness / pain** and radiates into my (name part of the body ie: arm, hand, etc.) \_\_\_\_\_.

The pain is worse with **sneezing / lifting / coughing / bowel movements**.

Additional comments: \_\_\_\_\_

Chart # \_\_\_\_\_

D.O.B. \_\_\_\_\_

Last Name \_\_\_\_\_

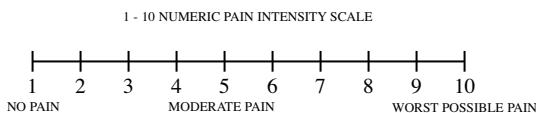
**\*\*\*Other Pain YES / NO**

Where? \_\_\_\_\_

When did it begin? \_\_\_\_\_ Do you feel it is related to this accident? **YES / NO**

The pain is **always / comes and goes**. The quality of pain is **dull / sharp / burning / other** \_\_\_\_\_

Rate your pain



The pain is **greater on the left / greater on the right / equal on both sides**.

Additional comments: \_\_\_\_\_

**\*\*\*PAIN SUMMARY**

The pain I am experiencing, from this accident, causes difficulty with **movement / standing / sitting / lying down / walking / riding in a car / bending / twisting / lifting / rising to walk after sitting**.

Does the pain radiate or travel? **YES / NO**

The pain radiates into the **base of the skull / neck / left arm / right arm / both arms / left shoulder / right shoulder / both shoulders / left leg / right leg / both legs**.

Other: \_\_\_\_\_

The pain is worse in the **morning / evening**.

**HOW DOES YOUR PAIN INTERFERE WITH YOUR LIFE?**

A. Circle the number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITIES**:

/ \_\_\_\_\_ /

0            1            2            3            4            5            6            7            8            9            10

**Does not interfere**

**Completely interferes**

B. Circle the number that describes how, during the past 24 hours, pain has interfered with your usual **SLEEP**:

/ \_\_\_\_\_ /

0            1            2            3            4            5            6            7            8            9            10

**Does not interfere**

**Completely interferes**

C. Circle the number that describes how, during the past 24 hours, pain has interfered with your usual **MOOD**:

/ \_\_\_\_\_ /

0            1            2            3            4            5            6            7            8            9            10

**Does not interfere**

**Completely interferes**

D. Circle the number that describes how, during the past 24 hours, pain has added to your usual **STRESS**:

/ \_\_\_\_\_ /

0            1            2            3            4            5            6            7            8            9            10

**Does not add to**

**Extremely adds to**

Chart # \_\_\_\_\_

D.O.B. \_\_\_\_\_

Last Name \_\_\_\_\_

**SECTION 3** Past history and medical illnesses.

Besides this accident, I **have** / **have not** been in any other accidents. If so, when? \_\_\_\_\_

There **were** / **were no** injuries.

Explain injury if applicable: \_\_\_\_\_

I was treated by: \_\_\_\_\_

I **was** /**was not** still under care for those injuries at the time of this current accident with Dr. \_\_\_\_\_

I **was** / **was not** healthy at the time of this current accident.

**PAST MEDICAL HISTORY:**

Have you had any of the following Illnesses? Circle all that apply.

- |                                    |                             |                                |                            |
|------------------------------------|-----------------------------|--------------------------------|----------------------------|
| Alcohol Overdose                   | Emphysema                   | Kidney Disease                 | Seizures                   |
| Allergies (other than medications) | Epilepsy                    | Kidney or Bladder              | Stomach Pain               |
| Anemia                             | Gallbladder Disease         | Infections (frequent)          | Stomach Ulcers             |
| Arthritis                          | Goiter                      | Lung Disease                   | Stroke                     |
| Asthma                             | Gout                        | Lung Infections (frequent)     | Swollen Joints             |
| Bleeding Tendency                  | Hay Fever                   | Other Medical Problems: _____  | Thyroid Disease            |
| Cancer Type: _____                 | Headaches - Migraine -Sinus |                                | Tuberculosis               |
| Chest Pain                         | Tension                     | Nausea                         | Urinary Problems           |
| Chronic Fatigue                    | Hearing Problems            | Nervous Breakdown              | Vision Problems            |
| Colitis                            | Heart Attack                | Pacemaker / Stents             | Vomiting                   |
| Congenital Heart Disease           | Heart Disease               | Polio                          | <b>Childhood Diseases:</b> |
| Constipation                       | Hepatitis A, B, C           | Rashes                         | Chicken Pox                |
| Depression                         | High Blood Pressure         | Sexually Transmitted Diseases: | Measles                    |
| Diabetes Type: I or II             | Intestinal Polyps           | AIDS, Syphilis, Gonorrhea,     | Mumps                      |
| Diarrhea                           | Irregular Heart Beat        | Herpes, HIV                    | Rheumatic Fever            |
| Difficulty Swallowing              | Irritable Bowel Syndrome    | Shortness of Breath            | Whooping Cough             |
| Dizziness                          | Jaundice                    | Sickle Cell Anemia             |                            |

**REVIEW OF SYSTEMS:**

R.O.S. Completed \_\_\_\_\_

Do you currently have any of the following? (circle all that apply)

- |                     |                  |            |                       |                |
|---------------------|------------------|------------|-----------------------|----------------|
| Headaches           | Stomach Pain     | Chest Pain | Vision Problems       | Nausea         |
| Shortness of Breath | Hearing Problems | Vomiting   | Urinary Problems      | Dizziness      |
| Constipation        | Rashes           | Diarrhea   | Difficulty Swallowing | Swollen Joints |
| Chronic Fatigue     |                  |            |                       |                |

**Hospitalizations:**

**Reasons & Approximate Dates:** \_\_\_\_\_

I **have** / **have never** had surgery. Name procedures and dates: \_\_\_\_\_

Do you have surgical scars? **YES** / **NO** If so, indicate where. \_\_\_\_\_

Any other past medical history the doctor should know? \_\_\_\_\_

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**Family History**

Father: If living: Age \_\_\_\_\_ Health \_\_\_\_\_ If Deceased: \_\_\_\_\_ Age \_\_\_\_\_ Cause \_\_\_\_\_

Mother: If living: Age \_\_\_\_\_ Health \_\_\_\_\_ If Deceased: \_\_\_\_\_ Age \_\_\_\_\_ Cause \_\_\_\_\_

**Brothers/Sisters:**

Male Female If living: Age \_\_\_\_\_ Health \_\_\_\_\_ If Deceased: Age \_\_\_\_\_ Cause \_\_\_\_\_

Male Female If living: Age \_\_\_\_\_ Health \_\_\_\_\_ If Deceased: Age \_\_\_\_\_ Cause \_\_\_\_\_

Male Female If living: Age \_\_\_\_\_ Health \_\_\_\_\_ If Deceased: Age \_\_\_\_\_ Cause \_\_\_\_\_

Male Female If living: Age \_\_\_\_\_ Health \_\_\_\_\_ If Deceased: Age \_\_\_\_\_ Cause \_\_\_\_\_

**PLEASE CHECK IF ANY BLOOD RELATIVE “HAS” OR “HAD” ANY OF THE FOLLOWING:**

	Yes	No		Yes	No		Yes	No
Arthritis	[ ]	[ ]	Epilepsy	[ ]	[ ]	Migraine	[ ]	[ ]
Asthma	[ ]	[ ]	Goiter	[ ]	[ ]	Nervous Breakdown	[ ]	[ ]
Bleeding Tendency	[ ]	[ ]	Gout	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Cancer	[ ]	[ ]	Hay Fever	[ ]	[ ]	Sickle Cell Anemia	[ ]	[ ]
Congenital	[ ]	[ ]	Heart Attack	[ ]	[ ]	Stomach Ulcers	[ ]	[ ]
Heart Disease			High Blood Pressure	[ ]	[ ]	Stroke	[ ]	[ ]
Diabetes	[ ]	[ ]	Intestinal Polyps	[ ]	[ ]	Suicide	[ ]	[ ]
Emphysema	[ ]	[ ]	Kidney Disease	[ ]	[ ]	Tuberculosis	[ ]	[ ]
			Leukemia	[ ]	[ ]	Other _____		

If “Yes” on any of the above, please indicate what relative had the condition: \_\_\_\_\_

**NOTES:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Chart # \_\_\_\_\_ D.O.B. \_\_\_\_\_ Last Name \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status:      Single              Married              Separated              Divorced              Widowed

Do you smoke cigarettes?    **YES / NO**    If yes, \_\_\_\_\_ packs per day for the last \_\_\_\_\_ years / months.

Do you drink alcohol?    **YES / NO**    How much? \_\_\_\_\_ What Kind? \_\_\_\_\_ for how long? \_\_\_\_\_

Have you missed work due to this accident?    **YES / NO**    How many days? \_\_\_\_\_

Have you returned work since your accident?    **YES / NO**    What date did you return? \_\_\_\_\_

Where do you work? \_\_\_\_\_ How long? \_\_\_\_\_ Doing What? \_\_\_\_\_

**Full / restricted duty / full time / part time**

**MEDICATION HISTORY:**

Please list all of your current medications including herbal and vitamin supplements, birth control pills, over the counter medications of any kind and all prescription drugs. \_\_\_\_\_  
\_\_\_\_\_

Have you experienced side effects from any medications?    **YES / NO**

List drug and side effect \_\_\_\_\_

Please indicate below if you are allergic to any **MEDICATIONS**. If none, please write “none”.  
\_\_\_\_\_

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date