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 preformed with the aid of a computer. If so, please indicate what area of your body was tested and at what facility was the test preformed?_____.

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 <u>currently</u> 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

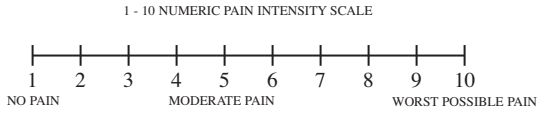
SECTION 2 Please circle the difficulties or symptoms you are currently experiencing.

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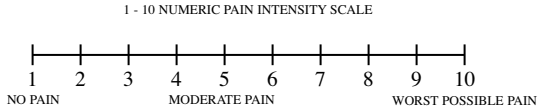
***Neck (Cervical) Pain YES / NO

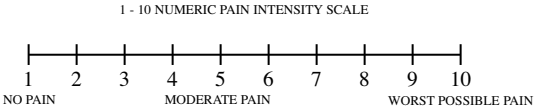
When did it begin? _____. Do you feel it is related to this accident? **YES / NO**
The pain is **always / comes and goes.** The quality of pain is **dull / sharp / burning / other** _____

Rate your pain



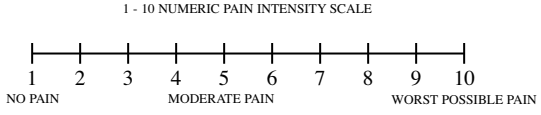
The pain is **greater on the left / greater on the right / equal on both sides**.
The pain **is / is not** associated with **pins & needles / numbness / pain** and radiates into my (name part of the body ie: arm, hand, etc.) _____.
The pain is worse with **sneezing / lifting / coughing / bowel movements.**
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** _____
Rate your pain



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** _____
Rate your pain



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:_____
_____.

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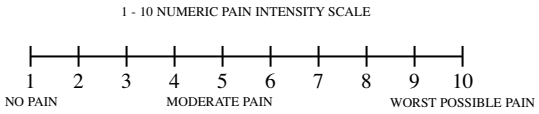
***Other Pain YES / NO

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**

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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	**Childhood Diseases:**
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