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:_____ Race:_____ Male / Female Left Handed / Right Handed

Height:_____ Weight:_____ Date of Injury/When condition began:_____

CHIEF COMPLAINT:

_____

_____

_____

_____

I have had the following tests done:

X-rays **YES / NO** If yes, what was x-rayed and where were they taken?

_____

MRI **YES / NO** If yes, what area was done and where was it taken?

_____

CT scan **YES / NO** If yes, what was scanned and where was it taken?

_____

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 where the test was preformed._____.

Other tests **YES / NO** _____.

_____

PAST TREATMENT:

Have you seen any other doctors for this complaint? **YES / NO** If so:

#1. 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? _____

#2. 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? _____

Chart # _____ D.O.B. _____ Last Name _____

#3. 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? _____

CURRENT TREATMENT:

I am currently under the treatment of Dr. _____

Address: _____

_____

Treatment currently includes: _____

_____

_____

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

TREATMENT FOR THIS CONDITION HAS (IS) INCLUDED THE FOLLOWING: (Please circle all that apply)

[ ] **Medications** (name & dosage): _____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Injections** (date & type): _____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Epidural Steroid Injections** (ESI's) (dates): _____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Physical Therapy** (type and duration): _____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Massage Therapy** (type and duration):_____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Traction** (type and duration): _____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Chiropractic** (type and duration): _____

_____

This treatment is/has helping(ed) very much / helping(ed) a little / not helping(ed) at all.

[ ] **Other** (type and duration):_____

_____

Chart # _____ D.O.B. _____ Last Name _____

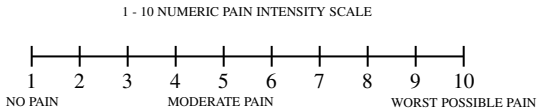
SECTION 2 Please circle the difficulties or symptoms you are currently experiencing.

***Headaches YES / NO**

When did they begin? _____

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:_____

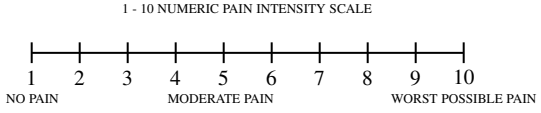
_____.

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

When did they begin? _____

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:_____

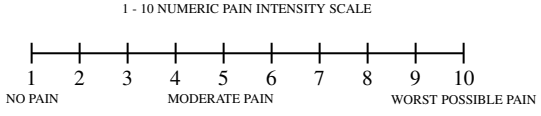
_____.

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

When did they begin? _____

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:_____

_____.

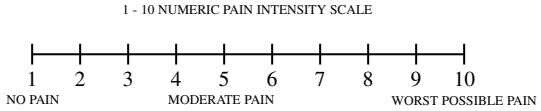
Chart # _____ D.O.B. _____ Last Name _____

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

When did it begin? _____

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:_____

_____.

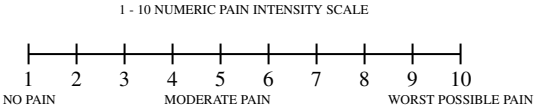
***Other Pain YES / NO

Where? _____

When did it begin? _____

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, 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**. It is worse following **routine / moderate** activities.

The pain interferes with **work / sleep / personal activities / other:**_____

REVIEW OF SYSTEMS: R.O.S. reviewed by:_____

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				

Chart # _____ D.O.B. _____ Last Name _____

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	

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?_____

_____

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_____

Chart # _____ D.O.B. _____ Last Name _____

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: _____

_____

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?_____

Do you use recreational drugs, ie; marijuana, cocaine? **YES / NO** How much? _____How Often? _____

For how long?_____

Have you missed work due to this injury? **YES / NO** How many days? _____

Have you returned to work since your injury? **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_____

ALLERGIES:

Please indicate below if you are allergic to any medications, contrast dyes, anesthesia, latex products, adhesives or anything else. **If none, please write "none"**. _____

_____

_____ _____

Patients Signature Date