SEACOAST AREA PHYSIATRY, P.C. CLINICAL QUESTIONNAIRE

Please complete this form as accurately and completely as possible as it will become part of your permanent medical record.

DATE_____NAME_____ DATE OF BIRTH_____ AGE_____ R/L HANDED

PLEASE DESCRIBE THE REASON(S) FOR TODAY'S VISITS.

1. _____

2. _____

DATE OF ONSET/INJURY OF SYMPTOMS _____ HAVE YOU EVER HAD SIMILAR SYMPTOMS PRIOR? ☐ **YES** ☐ **NO**

UNDER WHAT CIRCUMSTANCES DID YOUR CURRENT SYMPTOMS OCCUR?

☐ WORK RELATED
☐ MOTOR VEHICLE ACCIDENT
☐ OTHER_____

HAVE YOU EVER BEEN SEEN BY ONE OF OUR PROVIDERS AT SEACOAST AREA PHYSIATRY? ☐ **YES** ☐ **NO**

WHO IS YOUR PRIMARY CARE/ FAMILY PHYSICIAN? _____

WHO REFERRED YOU FOR TODAY'S EVALUATION? (Please identify by name)

PHYSICIAN _____ OTHER _____

HOW DID YOU HEAR ABOUT US? ☐ RADIO/ADVERTISEMENT ☐ OTHER _____

PLEASE PLACE A MARK ON THE SCALE BELOW THAT BEST DESCRIBES YOUR AVERAGE LEVEL OF PAIN.

NO PAIN 0_____ 10 WORST POSSIBLE PAIN

ARE YOUR SYMPTOMS:
CONSTANT? ☐ **YES** ☐ **NO**
INTERMITTENT? ☐ **YES** ☐ **NO**
RELATED TO ACTIVITY? ☐ **YES** ☐ **NO**

PLEASE LIST THOSE ACTIVITIES THAT INCREASE OR DECREASE YOUR SYMPTOMS

INCREASE	DECREASE
_____	_____
_____	_____
_____	_____

ARE YOUR SYMPTOMS: GETTING WORSE? ☐ GETTING BETTER? ☐ STAYING THE SAME? ☐

PLEASE STATE THE MAXIMUM AMOUNT OF TIME YOU TOLERATE EACH OF THE FOLLOWING ACTIVITIES:

SITTING_____ STANDING_____ WALKING_____
DRIVING_____ PASSENGER IN VEHICLE _____

HAVE YOU HAD PRIOR DIAGNOSTIC TESTING RELATED TO YOUR CURRENT COMPLAINT? ☐ **YES** ☐ **NO**

Please check the following tests that you have had done: X-ray ☐ MRI ☐ CT scan ☐ EMG/NCS☐ Bone scan ☐ Other ☐

PLEASE BRING ALL OF THE TESTS (FILMS AND REPORTS) ABOVE TO YOUR APPOINTMENT.

_____
Provider's Initial

PLEASE CHECK AS MANY OF THE FOLLOWING HEALTH PROBLEMS THAT YOU NOW HAVE OR HAVE HAD

☐ Anemia	☐ Cyst	☐ Lung Disease	☐ Tuberculosis	☐ Other psychiatric issues
☐ Blood disease	☐ Back problems	☐ Headaches	☐ Hepatitis	☐ Arthritis
☐ High Blood Pressure	☐ Disc problems	☐ Migraine	☐ Liver disease	☐ Bursitis
☐ Diabetes	☐ Multiple Sclerosis	☐ Bone	☐ Gallbladder Disease	☐ Ganglion
☐ Thyroid Disease	☐ Head Injury	☐ Joint Disease	☐ Heart Disease	☐ Loss of sight
☐ Allergy	☐ Stroke	☐ Amputation foot	☐ Heart Attack	☐ Ulcer
☐ Hay Fever	☐ Phlebitis	☐ Amputation leg	☐ Kidney trouble	☐ Seizures
☐ Asthma	☐ Blood clot	☐ Amputation arm	☐ Bladder trouble	☐ Epilepsy
☐ Cancer	☐ High Cholesterol	☐ Cerebral palsy	☐ Anxiety	☐ Ulcerative colitis
☐ Tumor	☐ Hernia	☐ Parkinson's Disease	☐ Depression	☐ Crohn's
				☐ Fibromyalgia

PLEASE LIST ANY OPERATIONS/SURGERY YOU HAVE HAD

_____ DATE_____

_____ DATE_____

_____ DATE_____

PLEASE LIST YOUR CURRENT MEDICATIONS INCLUDING PRESCRIPTION MEDS AND ALL OVER THE COUNTER MEDICATIONS OR SUPPLEMENTS ALONG WITH THE DOSAGE AND HOW OFTEN YOU TAKE EACH DAY.

_____

_____

_____

_____

DO YOU HAVE MEDICATION ALLERGIES? ☐ **YES** ☐ **NO** IF YES, PLEASE SPECIFY MEDICATION ALLERGIES –TYPES OF REACTIONS BELOW

_____

_____

FAMILY HISTORY	AGE	AGE AT DEATH	MEDICAL CONDITIONS
Mother	_____	_____	_____
Father	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Other	_____	_____	_____
Children	_____	_____	_____

SOCIAL HISTORY: ARE YOU SINGLE, DIVORCED, MARRIED, WIDOWED, OR LIVING WITH PARTNER?
DO YOU HAVE ANY CHILDREN? ☐ **YES** ☐ **NO**

TOBACCO USE: ARE YOU A
- ☐ CURRENT SMOKER
- ☐ FORMER SMOKER
- ☐ NEVER SMOKER
- ☐ CURRENTLY CHEW TOBACCO
- ☐ FORMERLY CHEWED TOBACCO

IF CURRENT SMOKER, HOW MANY/DAY? _____ x # of YEARS? _____

DO YOU DRINK ALCOHOL, BEER OR WINE? ☐ **YES** ☐ **NO** TYPE? _____ HOW MUCH PER DAY/WEEK?

HAVE YOU EVER USED ILLICIT OR RECREATIONAL DRUGS? ☐ **YES** ☐ **NO**

CURRENT WORK STATUS (PLEASE CIRCLE ONE)
FULL TIME PART TIME UNEMPLOYED RETIRED DISABLED OTHER _____

IF RETIRED OR DISABLED DATE OF RETIREMENT/DISABILITY _____

INTERESTS/HOBBIES _____ REGULAR EXERCISE ☐ YES ☐ NO

I verify, to the best of my ability, that the information I have provided is accurate and complete.

_____ _____

Patient Signature **Date**

Provider's Initial