behavioral medicine center

new patient questionnaire

Please take a few minutes to complete this form so we can get to know you better.

What is your understanding of why you have been referred to my office? _____

_____

CURRENT PROBLEMS: Please list the problems/complaints you are currently experiencing. Which *one* bothers you the most? (#_____)

1.)_____

2.)_____

3.)_____

4.)_____

5.)_____

6.)_____

TREATMENT HISTORY: Please check off ✓ each treatment modality/intervention you have had for your current injury/illness.

✓	Treatment Modality	Provider	Date or # of Visits	Was this helpful to you?
	Physical Therapy (land)			☐ Yes ☐ No ☐ Not Sure
	Pool Therapy			☐ Yes ☐ No ☐ Not Sure
	Occupational Therapy			☐ Yes ☐ No ☐ Not Sure
	Massage			☐ Yes ☐ No ☐ Not Sure
	Acupuncture			☐ Yes ☐ No ☐ Not Sure
	Osteopathic Manipulation			☐ Yes ☐ No ☐ Not Sure
	Chiropractic			☐ Yes ☐ No ☐ Not Sure
	Dry Needling/Prolo Therapy			☐ Yes ☐ No ☐ Not Sure
	TENS or Interferential Unit			☐ Yes ☐ No ☐ Not Sure
	Surgery(s):			☐ Yes ☐ No ☐ Not Sure
	Injection(s):			☐ Yes ☐ No ☐ Not Sure
	Trigger Point Injections			☐ Yes ☐ No ☐ Not Sure
	Steroid Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Facet or SI Injections			☐ Yes ☐ No ☐ Not Sure
	Selective Nerve Block(s)			☐ Yes ☐ No ☐ Not Sure

Over, please! →

	Epidural Steroid Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Sympathetic or Stellate Ganglion Block(s)			☐ Yes ☐ No ☐ Not Sure
	Behavioral Interventions:			☐ Yes ☐ No ☐ Not Sure
	Psychotherapy/Counseling			☐ Yes ☐ No ☐ Not Sure
	Biofeedback			☐ Yes ☐ No ☐ Not Sure
	Psychological Evaluation			☐ Yes ☐ No ☐ Not Sure
	Other:			☐ Yes ☐ No ☐ Not Sure

What providers are you *currently* seeing? _____

Are you satisfied with your providers and current medical care? ☐ Yes ☐ No; please explain: _____

_____

Are you currently performing a home exercise program?_____

Any upcoming surgeries, injections, or other procedures planned? _____

What are your goals for treatment?_____

_____

CURRENT MEDICATIONS: Please list *all* medications (prescription and over-the-counter) you are taking.

Medication Name	Dose (mg)	Time(s)/Day	Prescribing Physician	Is this med helpful?
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure

Are you currently taking any vitamins, homeopathic, or herbal supplements? ☐ No ☐ Yes; please list:

_____

Do you have any allergies to medications, latex, or adhesives? ☐ No ☐ Yes; please list: _____

MEDICAL HISTORY: Any prior surgeries, medical conditions/illnesses, or hospitalizations, not listed above?_____

Any significant **family** medical history (e.g. high blood pressure, diabetes, cancer, stroke, heart disease, neurological problems, autoimmune disease, thyroid problems, etc.)? _____