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 (✓) each treatment modality/intervention you have had for your *current* injury and/or medical conditions.

✓	Treatment Modality	Provider	Dates or # of Visits	Was this helpful?
	Physical Therapy			☐ Yes ☐ No ☐ Not Sure
	Pool Therapy			☐ Yes ☐ No ☐ Not Sure
	Occupational Therapy			☐ Yes ☐ No ☐ Not Sure
	Massage Therapy			☐ Yes ☐ No ☐ Not Sure
	Acupuncture			☐ Yes ☐ No ☐ Not Sure
	Osteopathic Manipulation			☐ Yes ☐ No ☐ Not Sure
	Chiropractic Manipulation			☐ Yes ☐ No ☐ Not Sure
	Dry Needling			☐ Yes ☐ No ☐ Not Sure
	TENS or Interferential Unit			☐ Yes ☐ No ☐ Not Sure
	Trigger Point Injections			☐ Yes ☐ No ☐ Not Sure
	Occipital Nerve Blocks			☐ Yes ☐ No ☐ Not Sure
	Joint or Local Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Epidural Steroid Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Facet or SI Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Selective/Sympathetic Nerve Block(s)			☐ Yes ☐ No ☐ Not Sure
	Surgery(s)			☐ Yes ☐ No ☐ Not Sure

Turn over, please! ➔

	Other Procedure(s)			☐ Yes ☐ No ☐ Not Sure
	Speech/Cognitive Therapy			☐ Yes ☐ No ☐ Not Sure
	Vestibular or Vision Therapy			☐ Yes ☐ No ☐ Not Sure
	Psychotherapy/Counseling			☐ Yes ☐ No ☐ Not Sure
	Biofeedback			☐ Yes ☐ No ☐ Not Sure
	Psychological Evaluation			☐ Yes ☐ No ☐ Not Sure
	Psychiatric Evaluation			☐ Yes ☐ No ☐ Not Sure
	Independent Medical Eval(s)			☐ 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? ☐ No ☐ Yes; how often?_____

Any upcoming surgeries, procedures, or new referrals pending?_____

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 medication 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:

_____

Any allergies to medications, latex, or adhesives? ☐ No ☐ Yes; please list: _____

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

_____

_____

Please circle/list any significant **family** medical history (i.e., high blood pressure, diabetes, cancer, stroke, heart disease, neurological problems, autoimmune disorders, thyroid disease, etc.): _____

_____