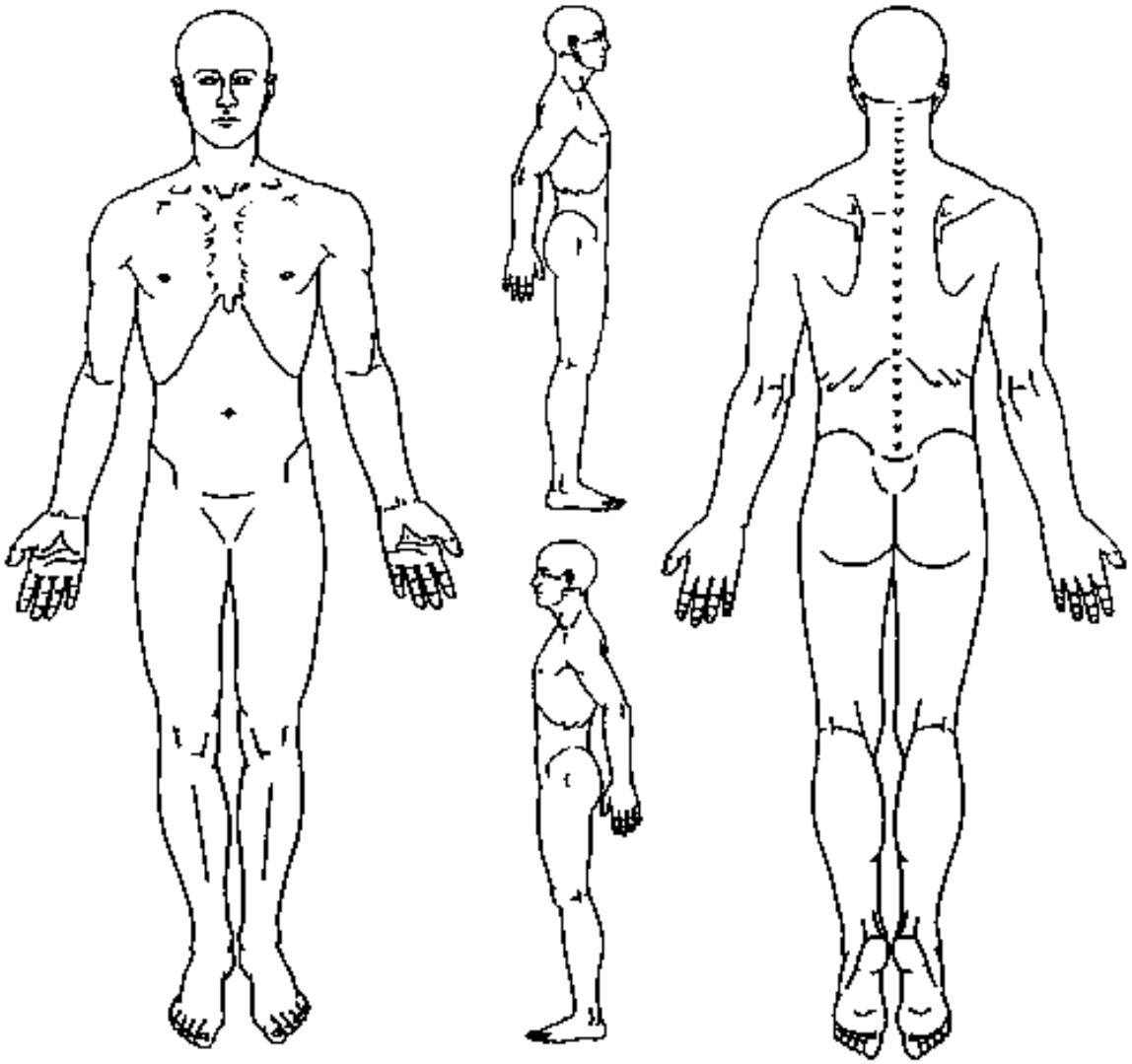
Alicia R. Carter, MD
Patient Questionnaire

Name: Age: Date:

Please mark the area(s) on the body diagram that correspond to your symptoms.

X=pain
O= numbness/tingling
Z= other

Front **Back**



Circle the words which best describe your symptoms:

Dull/Ache	Sore	Gnawing	Sharp/Stabbing
Shooting	Heaviness	Burning	Tightening/Constricting
Awareness	Throbbing	Weakness	Other: _____

How long have you had your current problem?

Please indicate your pain level when your pain is at its **LEAST.**

0 1 2 3 4 5 6 7 8 9 10
NO PAIN EXCRUCIATING PAIN

Please indicate your pain level when your pain is at its **WORST.**

0 1 2 3 4 5 6 7 8 9 10
NO PAIN EXCRUCIATING PAIN

Please indicate what your pain level is **MOST OF THE TIME**.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN EXCRUCIATING PAIN

What activities or positions make you pain **worse?**

What activities or positions make you pain **better?**

What functional limitations do you have because of your pain or other related symptoms?

Does your condition interfere with your ability to fall asleep or stay asleep? Please describe the type of mattress that you sleep on.

What diagnostic tests have you had for your condition, such as: **X-rays, MRI, EMG, etc.**

Please list all treatments that you have tried for your condition such as, physical/occupational therapy, chiropractic manipulation, massage, acupuncture, injections and/or medications (list specific medication names): Circle which treatments have helped you the most?

Please list any health conditions that you have such as diabetes, high blood pressure, asthma, thyroid disorders, heart disorders, lung disorders, history of cancer, headaches or arthritis. Please also list any ORTHOPEDIC conditions.

Are you under any type of emotional distress or do you suffer from anxiety or depression? If yes, are your currently receiving psychotherapy?

Please list the dates and the types of any surgeries that you have had:

Please list any medications, vitamins or nutritional supplements that you are currently taking:

Please list any medicine allergies that you have and the type of reaction that you had:

Please circle any of the following symptoms that you have experienced in recent months:

chest pain	shortness of breath	night pain	headaches	weight loss
fatigue	blurred vision	fever/chills	dizziness	nausea
vomiting	diarrhea	constipation	loss of bowel/bladder control	

Do you have a family history of spinal disorders? Please list any other major illnesses that run in your family:

What is your occupation or your former occupation (if you are retired or disabled)? What are the physical demands of your profession? Do you enjoy your occupation? Do you consider your occupation **mildly stressful**, **moderately stressful**, **very stressful** or **not stressful** at all (circle)?

Please describe what type of exercise, sports or recreational activity that you do on a regular basis. How often do you do each activity?

Do you smoke, drink alcoholic beverages or use illegal substances? How much and how often?

Who lives within your household?

What are your goals or expectations from treatment?