RIVERVIEW HEALTH

SC43

PATIENT QUESTIONNAIRE

Your appointment is with (circle one): Dr. Abbasi Dr. Kim

Patient Name: ____________ Date of Birth: _________________ Age: ____________

Phone: _____________ (cell/home/work) Secondary Phone: ___________(cell/home/work)

Occupation: ______________________________

Address: ____ City: __________________

State: __________________ Zip: __________

Emergency contact (other than above including phone number & relationship(____________________
____

Primary Physician: _________________________ Other Doctors: ___________________________

Referring Physician: ____

Insurance: Medicare – Medicaid – Workers com – Auto – BlueShield – OTHERS:

Social Security Number _______________ - _______________ - _______________

Emergency contact (other than above including phone number & relationship) _________________________
____

Primary Physician: ______________________________ Other Doctors: ___________________________

Referring Physician: ____

What is your main symptom and how long have you had these symptoms?

____
____
____

Please rate/circle your symptom from 1 (very mild) to 10 (very severe)

PAIN:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
NUMBNESS:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
WEAKNESS:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Bladder / bowel incontinent? Yes / No

How far can you walk? Walking not limited _____ Blocks Unable to Walk

Other symptoms:

____
____

Is your problem a result of an accident? Yes / No
If yes, where did this occur? Work / Home / Motor Vehicle / Other
Have you ever had a work comp or auto injury related to this body part? Yes / No
Is this currently open? Yes / No
Is a Lawsuit in progress or being planned? Yes / No
Do we have permission to discuss your care with your attorney? Yes / No

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Height:	Weight:
Recent weight gain or loss?	Dominant hand ☐ Right ☐ Left

PAST MEDICAL HISTORY (please circle any of the following medical problems you have or have had)

General	Neurological	Cardiovascular
Cancer Type:	Stroke	Heart attack
Arthritis	Brain tumor	Hypertension
Lupus	Headaches	High cholesterol
Thyroid Problem	Back injury	Atrial fibrillation
Diabetes	Neck injury	Pacemaker
Osteoporosis	Head injury	Carotid disease
Fibromyalgia	Seizure/Epilepsy	Coronary artery disease
Carpal Tunnel	Parkinson Disease	
	Multiple Sclerosis	**Genitourinary**
Lung		Kidney problem
Asthma	**Blood**	Kidney stones
Pneumonia	Anemia	Urinary tract infection
Emphysema	Blood clots	Bladder problem
Tuberculosis	Previous transfusion	Prostate problem
	Bleeding problems	
Psychological		**Other Conditions**
Anxiety	**Gastrointestinal**	
Bipolar Disorder	Hepatitis	
Depression	GERD/Heartburn	
Schizophrenia	Liver disease	
	Colitis	
	Ulcers	

Medications ☐ Non-steroidal (Ibuprofen/Advil/Tylenol etc.) ☐ Narcotic (Vicodin/Norco/Percocet

Allergies (Medications, Food or Latex): Type of Reaction Severity (Mild/Moderate/Severe)

Pertinent Imaging Studies Have Report? Have Films?

Date	Where	What
		MRI
		CT
		Discogram
		X-rays

Past Surgical History:

Have you had previous surgery for this problem? YES / NO IF YES, HOW MANY?_____________

When Where Surgeon Type of Surgery

Did it help? How long?

Did it help? How long?

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Conservative Therapy (within last 5 years)

Check	modality	Where	Dates / how long	Result
☐	Physical Therapy			
☐	Chiropractic Therapy			
☐	Injections			
☐	Other			

Social History

Marital Status ___ Married ____ Single ____ Divorced ____ Separated ___ Widowed

Children (living) ___ YES _____ NO

Race: ______________________________

Do you currently smoke? ___ YES ___ NO If Yes, how long?

How many packs daily? ________________

If you quit smoking, when did you quit?____

Would you be willing to quit smoking if Insurance required it? _____YES _____NO

Do you currently consume alcohol? ___ YES ___ NO

Socially How much do you drink daily?

Family

	Alive	Deceased	Age	Medical Problem or Cause of Death
Father	☐	☐	____	______________________________
Mother	☐	☐	____	______________________________
Others:	☐	☐	____	______________________________

Activities of daily living, I NEED HELP WITH FOLLOWING:

☐ 1. Personal hygiene – bathing, grooming and oral care

☐ 2. Dressing – the ability to make appropriate clothing decisions and physically dress

☐ 3. Eating – the ability to feed oneself, though not necessarily to prepare food

☐ 4. Maintaining continence – both the mental and physical ability to use a restroom

☐ 5. Transferring – moving oneself from seated to standing and get in and out of bed

What do you feel interferes most with your day-to-day activities due to this pain?

____

____

____