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INITIAL PATIENT QUESTIONNAIRE

Name / Nombre:____ Age/Edad: __________

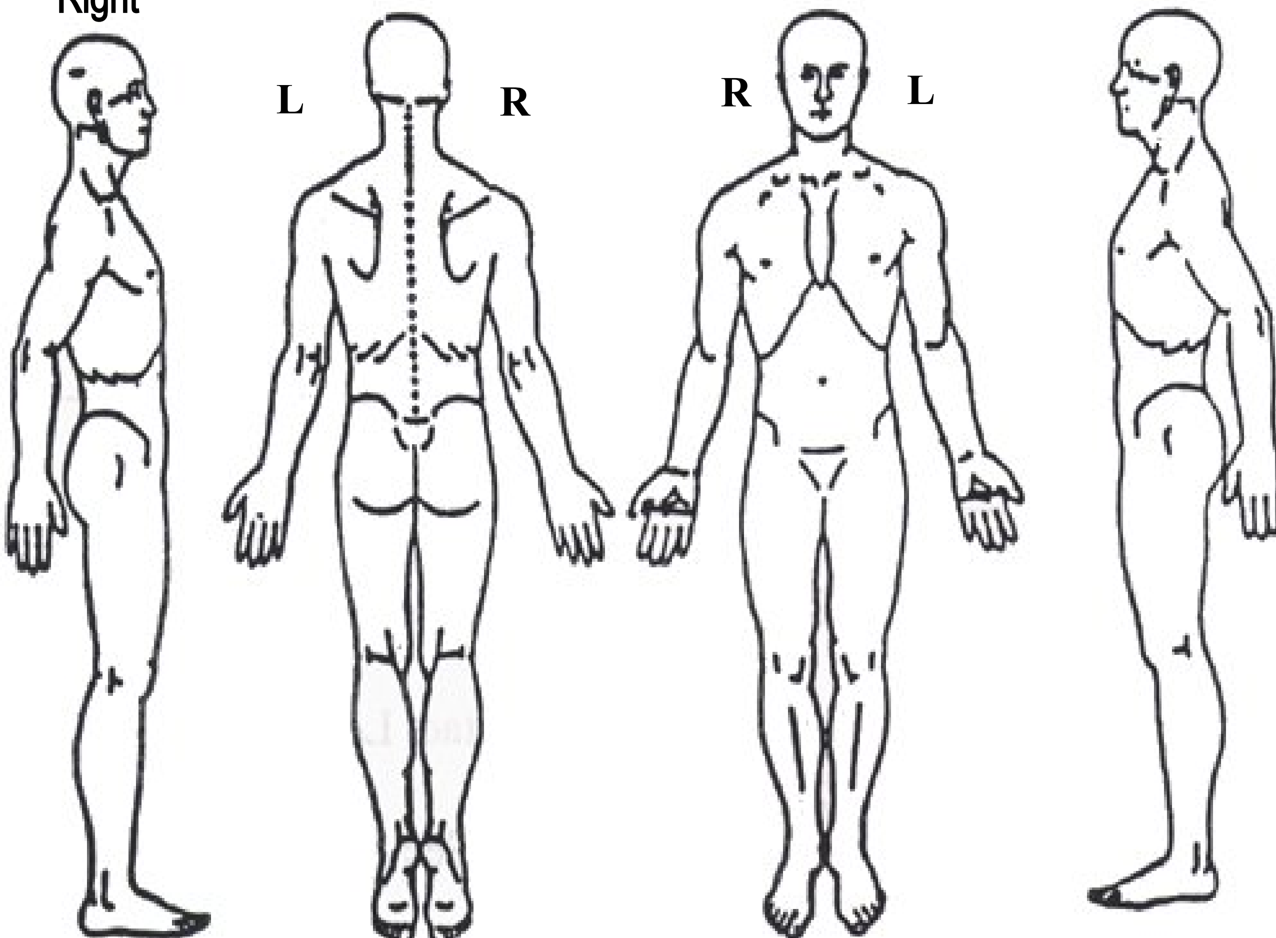
Reason for visit? / Rason por visita? ____

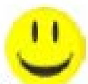
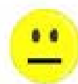
Headaches/Dolor de Cabeza   Dizziness/Mareos   Anxiety/Ansiedad   Sleep Disturbances/Problemas Durmiendo

When did your symptoms first appear? / Cuando comenzaron los síntomas? ______________________________

Is the condition getting progressively worst? / La condición se está empeorando? :   YES   NO

On pictures, mark pain level where you feel pain or discomfort / En las fotos abajo, marcar el nivel de dolor donde siente dolor :



0 ___ 1 ___ 2 ___ 3 ___ ___ 4 ___ ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

No pain / Nada de dolor   Excruciating Pain / Mucho Dolor

Are you currently under the medical care of another doctor? / Esta usted bajo la atención medica de otro doctor?

If so, when was your last visit / De haber visitado al doctor, cuando fue su última visita: ___________________________

List any major illnesses, with approximate dates / Liste sus condiciones médicas, con fechas aprox.:

____

____

Last Physical Exam:___________________ Last Blood Work : ____________________________

List any major surgeries or operations with approximate dates / Anota tus cirugía o operaciones, con fechas:

____

____ Is the condition getting progressively worst? / La condición se está empeorando? :

Indicate the type of pain / indica la clase de dolor : Aching Sharp Burning Throbbing

Other: ____________

Previous Treatments for this complaints / Tratamientos previos para esta condición:

____

____

Current medications / Medicamentos: ____

____

FEMALE PATIENTS ONLY

Are you Pregnant?

How many pregnancies?

Any additional comments: ____

HEIGHT: **FT** **Weight:** **Lbs.**

List any past accidents or injuries / Anotas algún accidente o herida: ______________________________________

____

Have you ever been diagnosed with the following? / Alguna vez te han diagnosticado con lo siguiente ?

○ Diabetes ○ Heart Disease ○ High Blood Pressure ○ Cancer ○ Asthma	○ Allergy ○ Tuberculosis ○ Herpes ○ STD ○ HIV/AID	○ Depression ○ Mental Disorder ○ Liver Problems ○ Hypo/Hyper Thyroidism ○ Vascular Disease	○ Mumps ○ Measles ○ Chicken Pox ○ Arthritis ○ Suicide

Any family history of serious illnesses / Tiene una historia de enfermedad familiar: Cancer Diabetes Heart Disease Gout

Are you taking any nutritional supplements? / Esta tomando suplementos nutritivos?

if so what kind/si, si que clase: ______________________________

Cigarettes: How many years smoking?: ___________ How many cigarettes a day? _____ Coffee how many cups a day ___ Energy Drinks a day? ____

Alcohol how many drinks a week? ______

Are you currently experiencing any of the following? / Estas experimentando alguno de lo siguiente ?

HEENT	Cardio Respiratory	Gastrointestinal	Gentourinary	Neuropsych
○ Hair Loss / Scalp Pain ○ Difficulty w/ Vision ○ Double Vision ○ Diffculty Hearing ○ Ringing of Ears ○ Difficulty Breathing ○ Nasal Discharge ○ Difficulty Chewing ○ Difficulty Swallowing	○ Chest Pain ○ Left Arm Pain ○ Palpations ○ Coughing ○ Wheezing ○ Short Breath ○ Asthma ○ Allergy ○ Discharge ○ Fatigue	○ Abdomen Pain ○ Diarreha ○ Bloating ○ Constipation ○ Gerd ○ Pencil Stool ○ Liver Problem ○ Loss / Gain of Weight ○ Cramps ○ Rash Skin	○ Discharge ○ Hesitancy ○ Frequency ○ Bladder Control ○ Pain urination ○ Sexual Dysfunction	○ Dizziness ○ Confusion ○ Depression ○ Fatigue ○ Numbness ○ Tingling ○ Sweats ○ Fever ○ Memory Loss ○ Suicide ○ Abuse

List Any Allergies/ Alergias:______________________________

Any pacemakers, stimulators or internal hardware? Example: Shunts, Dorsal Column Stim?______________________________

Any Additional Comments / Comentario

adicional:______________________________

Previous X-rays or MRI's ______________________________

Married: Yes No

Children: Yes No How many: ________

Work description and Hobbies: ______________________________

Patient Signature: ______________________________