



Initial Questionnaire

To help us serve you better, please answer the following questions.

Date: _____

Age: _____

Are you right or left-handed?

Right

Left

Date of Injury: _____

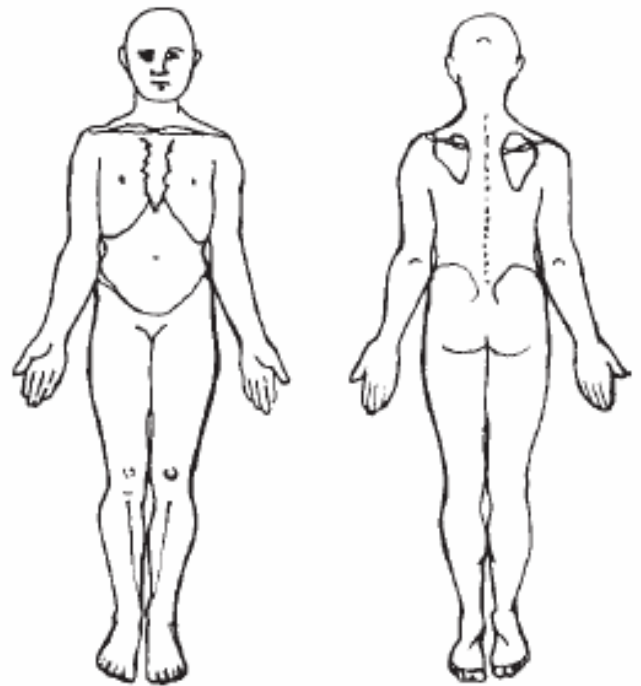
Occupation: _____

Please explain in **detail** what happened to you at work that caused you to become ill or injured. How did it happen? When did it happen? What part of your body did you injure?

What body part did you injury? Shade in the area(s) below:

Have you injured this body part before? Yes No

When?: _____



Prior Treatment:

What doctor(s) have seen you for this problem? _____

Have you had physical therapy? Yes No

If yes where? _____ When: _____

Have you seen a chiropractor? Yes No

Are you using any braces or splints? Yes No

Check the tests you have had. EMG MRI CT Scan X-ray

PLEASE TURN OVER =>

Occupational History:

What are your main job duties: _____

How long have you had this job? _____

Are you working? Yes No

If you are not working, when was your last date of work? _____

Past Medical History:

To your knowledge, do you have any of the following: (**Circle**)

Diabetes Cancer Arthritis High Blood Pressure Cardiac Disease Osteoporosis

Lung Disease Liver Disease Kidney Disease Thyroid Disease Ulcers

List all of your medications:

Please list known allergies: _____

Social History:

Do you smoke? Yes No If yes, how many packs per day? _____

Do you drink alcohol? Yes No

Are you pregnant? Yes No

Do you have children? Yes No If yes, how old are they? _____

Who do you live with? _____

List hobbies/recreational activities you participate in? _____

How many hours do you sleep per night? _____

Thank you!