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New Patient Questionnaire Sheet

Today's Date: __________________

Your Name: ___________________________________**Middle Initial or name:**_____________**Last Name:**______________________________

Date of Birth: ___________________**Age:**______________**Referred by:**____

For what reason are you seeing the Doctor :____

____

Developmental History (Specify on line provided):

Birth Place:______________________________**Place Raised:**_______________________________________

Number of Siblings:_________________Your Order (First, Middle, etc.):____________________________________

Mother's Age at Birth:_________Mother's Occupation During your Childhood:______________________

Relationship with Mother through Childhood:____

Father's Age at Birth:_________Father's Occupation During your Childhood:________________________

Relationship with Father through Childhood:____

List if Other Raised you: **(Stepfather, Grandma, etc.)**____

From what age did they raise you?____________________ To what age did they raise you if not 18?______

Their Occupation During your Childhood:____

Current History

Handedness(circle one): Right Left Ambidextrous. **Highest Education Level Completed**____________

Current Occupation:___________________________________**Current work hours per week**:________________

Ethnicity:___________________ **Religious or Other Group Affiliation**:___________________________________

Marital Status (Circle one): Single Married Divorced Remarried Separated Widowed

Number of Children:_________**List Children's ages**:____

Current Living Arrangements (Circle one): Live Alone Live w/ Roomate Live w/ Spouse Live w/ Parents Nursing Home

Other:____

List Recreational Hobbies/Activities:____

____

____

List Group(s) or Organization(s) involved in:____

____

____

Developmental History Continued (Check all that apply, specify on line provided):

Birth Complications

- ☐ Low Birth Weight
- ☐ Deformity (specify)_____________
- ☐ Oxygen Deprivation
- ☐ Illness (specify)_____________
- ☐ Premature
- ☐ Birth Trauma

Developmental Milestones (Check, if any, event(s) were delayed/impaired during infancy/toddler stages):

- ☐ Standing
- ☐ Talking
- ☐ Bedwetting
- ☐ Walking
- ☐ Potty Training

Childhood Diseases/Surgeries:

- ☐ Loss of Consciousness
- ☐ Seizure
- ☐ Concussion
- ☐ Oxygen Deprivation
- ☐ Tonsillectomy
- ☐ Near Drowning
- ☐ Convulsions
- ☐ Accidental Poisoning
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Appendectomy
- ☐ High Fever (over 104F)
- ☐ Cerebral Palsy
- ☐ Pneumonia
- ☐ Multiple Sclerosis
- ☐ Allergies______________
- ☐ Cut Requiring Stitches
- ☐ Asthma/Bronchitis
- ☐ Broken Bones_______________
- ☐ Cancer
- ☐ Other _____________________

Educational History

Special Education Classes or Learning Disabilities

- ☐ Yes, List_____________________________________
- ☐ No

Checklist of Current Medical Symptoms or Problems

Place an (X) in front of items you have or have had problems with

Acid reflux (heartburn)
____ Alcoholism / other addiction
____ Allergies (environmental)
____ Anxiety
____ Asthma
____ Arthritis
____ Cancer (specify type __________________)
____ Coagulation (bleeding or clotting) problem
____ Cholesterol problem
____ Chronic low back pain
____ Dementia
____ Depression
____ Diabetes mellitus
____ Erectile dysfunction
____ Gastric (GI) Issues
____ Head Injury
____ Heart disease (specify type_____________)
____ Hypertension (high blood pressure)
____ Irritable bowel syndrome
____ Irregular Heart beat/rhythm
____ Migraines
____ Musculoskeletal Problems
____ Osteopenia or Osteoporosis
____ Prostate problem
____ Pulmonary Issues (Lung/Breathing)
____ Stroke
____ Thyroid problem
____ Urinary Issues
____ Brain Injury

Early School Behavioral Patterns or Problems , Hyperactivity, etc. ___________________________________
____

____ Other Problems/Disorders/Diseases (list below):

____
____
____
____
____
____
____
____

Review of Symptoms

Place an (X) in front of items you have:

Vision:

_____________ Glasses/Contacts
_____________ Blurred or Double Vision
_____________ Loss of Vision/Blind Spots

Hearing:

_____________ Hearing Aid (left, right, or both ears)
_____________ Loss of Hearing
_____________ Ringing
_____________ Tone Deafness
_____________ Ear infections (tubes placed)

Motor: (specify where on line)

_____________ Decreased Coordination
_____________ Weakness
_____________ Paralysis
_____________ Spasms/Tremors
_____________ Chewing/Swallowing
_____________ Range of Movement/Flexibility

Tactile: (specify where on line)

_____________Numbness/Loss of Sensation
_____________Tingling/Burning
_____________Pain/Temperature Sensitivity

Taste & Smell:

_____________Change in Taste
_____________Bad Tastes
_____________Change in Smell
_____________Bad Smells

Consciousness:

_____________Seizures or Fits
_____________Fainting or Blackout Spells
_____________Lapses of Time
_____________Dizziness While Sitting
_____________Dizziness Upon Standing
_____________Staring Episodes

Pain: (specify where on line)

_____________ Chronic Pain (Long term)
_____________ Acute Pain (Short term, due to injury, sprain, etc)

Review of Cognitive Symptoms

Place an (X) in front of items you have:

Attention:

_____________ Distractibility
_____________ Confusion/Orientation Deficits (forgetting day, date, or whereabouts)
_____________ Concentration Deficits (Must repeatedly read a book or newspaper before it makes sense. Cannot follow television show from start to finish)
_____________ Path Finding Problems (Patient gets lost going to familiar places and/or has problems taking a bus)

Memory:

_____________ Immediate Memory (names, faces, telephone numbers)
_____________ Visual Memory Problems
_____________ Verbal Memory Problems
_____________ Memory Change (example) ____
_____________ Short-term Recall - Difficulty remembering newly learned experience.
_____________ Long-term or Remote Recall - Difficulty remembering past experiences/events
_____________ Absent-Mindedness
_____________ Memory for Names/Faces
_____________ Memory for Numbers
_____________ Old Learning (e.g., taking a bus, cooking a meal/dish, simple math/spelling)
_____________ New Learning (able to learn something new involving 3 or 4 steps)

Speech:

______________ Difficulty Expressing Thoughts
______________ Difficulty Understanding Others
______________ Change in Articulation/Slurred or Mumbled Speech
______________ Trouble Finding Correct Word or Desired Word
______________ Saying Wrong or Inappropriate Word
______________ Word-naming Problems
______________ Hesitations
______________ Substitutions
______________ Speech Impediments
______________ Difficulty Constructing Sentences

Thought Processes:

______________ Trouble Organizing Thoughts
______________ Trouble Organizing Actions
______________ Slowed Thinking
______________ Decreased Problem Solving Ability
______________ Changes in Ability to Read
______________ Changes in Ability to Write
______________ Changes in Ability to Spell
______________ Changes in Ability to do Math

Other Symptoms:

______________ Unexplained or Increased Crying Capacity
______________ Sadness
______________ Hyperactivity
______________ Temper Outbursts
______________ Irritability/Argumentativeness
______________ Impulsiveness
______________ Change in Motivation
______________ Loss of Pleasure
______________ Anxiety/Tension/Nervousness
______________ Fears
______________ Social Withdrawal/Isolation
______________ Change in Alcohol or Tobacco Use
______________ Racing Thoughts
______________ Worry
______________ Sleep Change (specify) ______________
______________ Number of Hours per Night____________
______________ Stress-related Sleep Difficulties
______________ Weight Loss/Gain
______________ Appetite Change
______________ Intentional Weight Loss
______________ Libido Changes
______________ Mood Swings
______________ Agitation/Panic Attacks
______________ Hallucinations
______________ Delusions
______________ Suicide Attempts/Gestures/Ideation
______________ Suicidal Thoughts/Ideation

Schools Attended (List Schools Attended from High School through College/Vocational or Professional School):

Name of School	Located in City, State	Attended From what Age to What Age?	Years Attended	Type of School, Degree/Special Awards Earned	GPA
1.					
2.					
3.					

Occupational History (List Summary of Job/Career History from past to present):

Company	Job Title	Approximate Dates From Date to End Date	Tasks of Job	Problems with Job? If Yes, list specific problems.
1.				
2.				
3.				
4.				

Disability Status (Have you been determined Disabled?)

☐ Yes, Specify:___________________________ ☐ No

Military Service

Branch	When ?	Length of Service	Where?	Rank	Service related injuries, disorders, limitations, exposures, etc.

Legal History

(Check the box(s) of all legal matters you have been involved in from school age to present, then explain checked items in the table that follows)

- ☐ Truancy
- ☐ School Suspension
- ☐ Court matters
- ☐ Misdemeanor Charges
- ☐ Felony Charges
- ☐ Jail/Prison Time
- ☐ Probation/Parole
- ☐ Victim of a Crime
- ☐ Victim of Violence
- ☐ Lawsuit
- ☐ DUI
- ☐ Assaults
- ☐ Drug Possession Charges
- ☐ Public Intox
- ☐ Other Legal Charges
- ☐ Accused of Abuse
- ☐ Victim of Abuse
- ☐ Parental Rights Taken by DHS/other legal entity
- ☐ Other:_______________

Legal History Detail

What:	Explanation/Further Details:	When (Estimated Date):	Where (What State/Specific Legal Entity):	Result/Consequences:

Substance Use

What Substance? Tobacco? Alcohol? Marijuana? Prescription Pills? Cocaine? Meth? Etc. List All.	Used From What Age to What Age?	How often and How much each time?	Any Legal or other Consequences from using?

Current Medications:

Medication Name	Dose (mg)	How Often (Once Daily, 2x day, PRN, etc.)	For what? (Pain, HTN, DM, etc.)

Additional Information You would like to share with doctor:____

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