AVAIL
SOFT TISSUE & SPINE

Confidential Patient Questionnaire

Patient Information

Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Today's Date: _____/_____/_____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

Preferred: Home ___ Work ___ Cell ___ How do you prefer to be verbally addressed?_____

E-mail: _____ **Sex:** M-F Marital Status: S-M-D-W **Age**: _____

Primary Care Physician: _____ Phone: _____

City: _____ State: _____ Zip: _____

How did you hear about Avail? _____

Employment Information

Employer & Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Emergency Contact Name: _____ Phone: (_____) _____

Agreement and Release

I, the undersigned, certify that I (or my legal dependent) am financially responsible for all charges. I hereby authorize the provider to relate all information necessary to secure payment. I submit this information to being accurate and true to the best of my knowledge.

Patient/Legal Guardian: _____ Date: _____/_____/_____

Primary Complaint Form

Primary Complaint (only one): _____

Additional Complaints: _____

When did this begin? _____ How did it begin? _____

Pain Type: Sharp ___ Stabbing ___ Dull ___ Achy ___ Sore ___ Weakness ___ Throbbing ___
Burning ___ Tingling ___ Numb ___ Shooting ___ Constricting ___ Other _____

Other Symptoms? Please Describe: _____

Severity: 0 = No pain 10 = Worst Pain _____ (1-10) How often is the pain? (% of day) _____

Since starting, has your pain: Increased ____ Decreased ____ No Change ____ Varies ____

What makes it worse? Nothing ___ Walking ___ Sitting ___ Standing ___ Riding in a car ___
Lifting ___ Bending ___ Stretching ___ Twisting ___ Other _____

What makes it better? Rest ___ Sitting ___ Standing ___ Meds ___ Ice/Heat ___ Other _____

When is it the worst? Morning ____ Afternoon ____ Evening ____ Night ____ Always ____

Has this affected your sleep? Yes ___ No ___ If "yes", please explain: _____

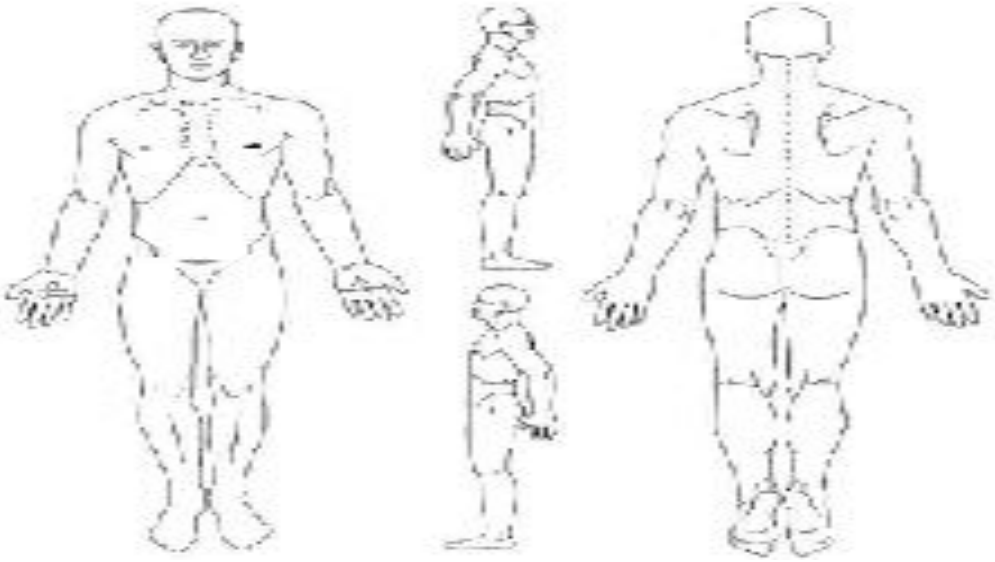
Any dizziness? Yes - No Fever or chills? Yes - No Change in bowel/bladder function? Yes - No

Does this affect your activities of daily living? No ___ Mildly ___ Moderately ___ Significantly ___

Does your work require you to: Sit (Hours:____) Stand (Hours:____) Lift Things (Light __ Heavy ___)

Using the diagram below, please indicate where you are experiencing symptoms:

N = Numbness **B** = Burning **S** = Sharp/Stabbing **T** = Tingling **D** = Dull/Achy **O** = Other (describe)



Primary Complaint Continued

Have you seen anyone for this condition? (MD, PT, DC, etc) Yes ____ No _____

Treatment type/imaging (X-ray, MRI)? _____

Findings on imaging: _____

If necessary for best treatment outcome, is it okay to contact your primary physician? Yes ___ No ___

Have you broken any bones? Yes ___ No ___ If yes, please explain _____

Do you take any non-prescription drugs? Aspirin ___ Tylenol ___ Ibuprofen ___ Other: _____

Please list any prescription medications: _____

Any allergies to drugs or other products? Yes ___ No ___ If yes, please explain _____

Hospital/Surgery History, please describe: _____

Do you smoke? Yes ___ No ___ Consume Alcohol? Yes ___ No ___ Exercise? Yes ___ No ___

Exercise Frequency: _____ times/week Exercise Intensity: Mild ___ Moderate ___ Intense ___

Exercise Routine (running, crossfit, etc.) _____

What do you like to do, but can't due to pain? _____

Health History/Medical Conditions (check all that apply)

AIDS/HIV	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorder	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Other	
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No		
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No		

Family History (check all that apply)

Arthritis ___ Cancer ___ High Cholesterol ___ Diabetes ___ Heart Problems _____
High Blood Pressure ___ Psychiatric ___ Stroke ___ Thyroid ___ Other _____

Patient/Legal Guardian Signature: _____ Date: _____/_____/_____