ACUPROLO INSTITUTE
RESTORATIVE HEALTH & NONSURGICAL PAIN CENTER

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INITIAL HEALTH QUESTIONNAIRE (page 1 of 2)

We appreciate you taking the time to complete this initial health assessment questionnaire. By thoroughly filling it out, this will allow your doctor to get a more comprehensive picture of your current health status. Mark each question either "yes" or "no" if at all possible. If uncertain on how to answer the question, place a question mark (?) there. You may write "none" or NA" if not applicable.

NAME:	**Date of birth:**	**Height:**	**Weight:**

REFERRED BY: □ Friend (name)_____ □ Internet □ Flyer □ Other: _____

CHIEF CONCERNS: Please briefly list the major reason(s) you are consulting our physicians:

1._____
2._____
3._____

GOALS: What are your health related goals?

1._____
2._____
3._____

HISTORY OF PRESENT ILLNESS

1. When did you first notice the problem? _____
2. What do you believe caused the problem? _____
3. Was there an incidence of trauma or accident in the past? _____

_____

4. How frequently do you experience pain? (daily, weekly, monthly, etc…)_____
5. Which terms best describe the pain? □ Pressure □Burning □ Pins & needles □ Cramping □ Sharp
   □ Achy □ Nagging □ Dull □ Shooting
6. What helps you with the pain (relieving factors)? _____

_____

7. What factors aggravate or make the pain worse? _____

_____

8. Do you have any loss of strength or sensation? If so, please describe: _____

_____

9. Please list all the doctors you have seen for this problem, including any specialists:_____

_____

10. Please list all the diagnostic tests you have had for this problem (Xrays, CT scans, MRIs, other) and the dates they were taken: _____

_____

11. Have you had physical therapy for this problem? If so, please list where, when and physical modalities used

_____

12. Do you play any sports or are you involved in physical activities? If so, which ones:_____

_____

13. List the activities with which your problem has interfered (including daily activities, social and recreational activities:

_____

INITIAL HEALTH QUESTIONNAIRE (page 2 of 2)

14. Have you retained services of an attorney for this problem? □ No □ Yes, Name:_____
15. Are you involved in a worker's compensation case for this problem? □ No □ Yes

PAST SURGICAL HISTORY: Please list any surgeries you have had in your lifetime, and include the year.

1. _____ 2. _____3. _____
4. _____ 5. _____□ I've never had any surgeries

PAST MEDICAL HISTORY: □ None, I am generally healthy

□ Arthritis □ Diabetes □ High blood pressure □ High cholesterol □ Thyroid disease □ stroke
□ Cancer □ Heart □ Stomach problems □ COPD/ emphysema □ Asthma □ Depression
□ other: _____

MEDICATIONS: Please list all the medications you are currently taking. Include doses, and frequency.

Prescription Routine meds:	NON prescription, over the counter pills (include all vitamins)	Pain meds: (list all you have tried in the past)
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____
6. _____	6. _____	6. _____
7. _____		

ALLERGIES: Please list any medication allergies you have had and the reaction:_____
□ I have no known drug allergies □ I have the following food allergies: _____

FAMILY HISTORY: Please check the box if the following conditions run in our family and list the people who have had them (parents, grandparents, siblings, etc…)

□ Arthritis, who?_____□ Diabetes, who?_____
□ High blood pressure, who?_____□ Stroke, who?_____
□ Heart attack, who?_____□ Cancer, who?_____
□ other, who?_____

SOCIAL HISTORY:

1. Do you smoke? If yes, please include number of years.□ NO □ Tobacco _____□ Cigars ____□ Marijuana _____
2. Do you drink alcohol? □ No □Yes, occasionally □ Yes, Frequently, type of alcohol & amount:_____
3. Do you use any illicit drugs? □ No □ Yes. What kind_____
4. Do you have a known history of any exposure to toxic substances? No □ Yes. _____
5. Who do you live with? _____
6. What is your occupation? _____

Thank you for completing this questionnaire. If there is anything else you think we should know at this time, please feel free to use the space below. _____

_____

_____

_____

Patient Signature: _____Date:_____