Meggison CHIROPRACTIC CEDAR POINT

New Patient Questionnaire

Patient Name: _____

Chief complaint: _____

1. **When did the current complaint start?** _____
2. **How did it start?** _____
3. **What makes it worse?** _____
4. **What makes it better?** _____
5. **The pain is: (Circle All That Apply)**

Sharp Stabbing Dull Achy Numb Tingling Tightness Burning Throbbing

6. **Does it travel down the arm or leg? Yes or No**
7. **On a 0-10 (0= no pain, 10= worst pain) how bad is the pain?** _____
8. **Is the pain constant or does it come and go? How Frequent?** _____
9. **Have you had this pain before?** _____
10. **Any other treatment?** _____
11. **Recent diagnostic test?** _____
12. **Activities of daily life that are difficult?** _____
13. **Head, ear, nose, throat, eye issues?** _____

    Heart or lungs? _____

    Bowel or bladder? _____

    Skin? _____
14. **Surgical history: Procedure and approximate date**

_____

_____

_____
15. **Illnesses**: _____
16. **Medications**: _____
17. **History of accidents**: _____
18. **Work requirements**: _____
19. **Exercise?** _____**Nutrition**_____
20. **Secondary complaint**: _____ **0-10?** ___ **Type of pain**: _____
21. **Female Patients: Is there a chance that you are pregnant? Yes or No**