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NORTH BROWARD NEUROSPINAL SURGERY

MEDICAL QUESTIONAIRE

Patient Name:_____ Date of Birth: _____/_____/_____

1. Reason for Visit (If pain, mention body part):_____

2. Date of Onset/Duration of Symptoms:_____
3. What conservative treatment have you had since your injury/problem began?

___Ice/Heat ___Chiropractic Care
___Physical Therapy ___Acupuncture
___Previous Medications:_____

4. On a scale of 0-10 (with 10 being the worst pain imaginable), how would you score your pain today? ____/10
5. Check the words that best describe the character of the pain you are having today:

___Aching Pain ___Numbness ___Sharp Pain ___Shooting Pain ___Burning Pain
___Throbbing Pain ___Stabbing Pain ___Other:_____

6. What makes your symptoms better?_____
7. What makes your symptoms worse?_____

WORK/MOTOR VEHICLE INJURY

1. Is your injury work-related? ___Yes ___No
2. Do you have any work restrictions? ___Yes ___No
3. Have you missed any work as a result of this injury? ___Yes ___No
4. Is your injury due to a motor vehicle accident? ___Yes ___No

   If Yes:
   a. Were you wearing a seatbelt? ___Yes ___No
   b. Did you hit your head? ___Yes ___No
   c. Did you lose consciousness? ___Yes ___No
   d. Were the airbags of your vehicle deployed? ___Yes ___No
   e. How fast was your car traveling?_____
   f. How fast was (were) the other car(s) traveling?_____
   g. Were you the driver, front passenger, rear passenger, or pedestrian?_____
   h. Were you hit from the back, front, driver, passenger, or driver side?_____
   i. Did you go to the hospital after the incident? If so, which hospital?_____

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