

Beacon Orthopaedics and Sports Medicine Health Questionnaire

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____ Unmarried Married

Name of Family Doctor: _____

Who referred you to this office?

- | | | |
|--|--|---|
| <input type="checkbox"/> Advertisement | <input type="checkbox"/> Employer | <input type="checkbox"/> Occupational medicine clinic |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Family Physician | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Self | |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Specialty Physician | |

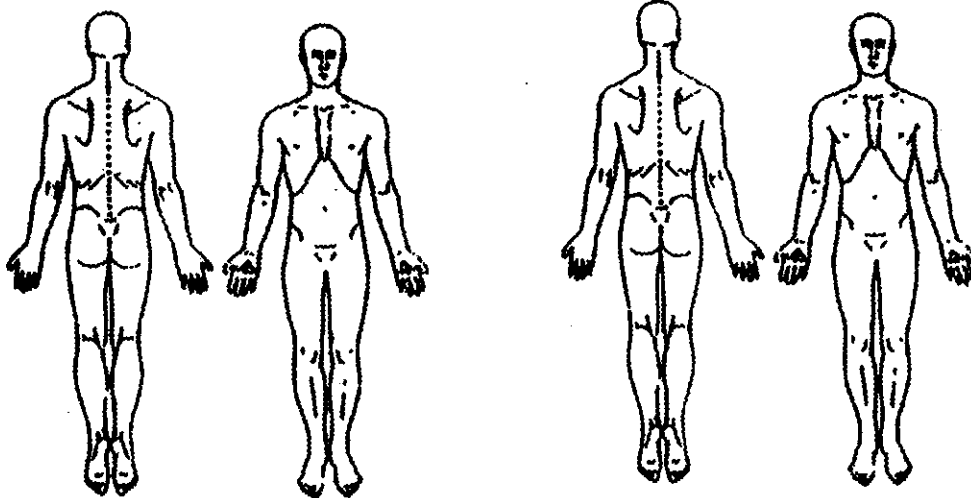
Name: _____

Date of onset: _____

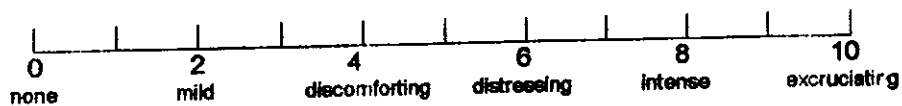
Describe your current disorder:

Show where you have pain:

Show where you have tingling or numbness:



Indicate your level of pain:



Which activities make your symptoms worse?

- Lying down
- Sitting
- Standing
- Exercise
- Walking
- Bending forward
- Bending backward
- Coughing

- Sneezing
- Other:

Which activities make your symptoms better?

- Lying down
- Sitting
- Standing
- Exercise
- Walking
- Stretching
- Manipulation
- Physical therapy

- Medication
- Other:

Who has treated you for this disorder?

- No one
- Chiropractor
- Company Doctor
- ER Physician
- Family Physician
- Medical Neurologist
- Neurosurgeon

- Occupational Medicine Physician
- Orthopedic Surgeon
- Osteopathic Physician

What treatments have been prescribed?

- None
- Acupuncture
- Brace
- Injections
- Manipulation
- Massage Therapy
- Pain Management Program
- Pain Medication
- Physical Therapy
- Work Hardening Program

- Other:

What testing has been done?

- None
- Blood Tests
- Bonescan
- CT scan
- DEXA scan
- Discography
- EMG/NCV
- Functional Capacity Testing
- MRI
- Myelogram
- X-Rays

- Other:

Are you being treated for the following medical conditions?

- | | | |
|--------------------------|--------------------------|-----------------------------|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's/
Parkinson's |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac arrhythmia |
| <input type="checkbox"/> | <input type="checkbox"/> | Coronary artery
disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |

- | | | |
|--------------------------|--------------------------|----------------------------|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches/migraine |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/liver
disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral
neuropathy |

- | | | |
|--------------------------|--------------------------|--------------------------------|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral vascular
disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostrate disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach
ulcers/reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Vertigo/dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: |

Have you had any of the following surgeries?

Y N

- Appendix
- Bowel or colon
- Cancer surgery
- Cardiac cath
- Carpal tunnel
- Cataract/eye
- Colonoscopy/EGD
- Coronary bypass

Y N

- Fracture surgery
- Gall bladder
- Hysterectomy
- Joint arthroscopy
- Joint replacement
- Low back
- Neck
- Pacemaker implant

Y N

- Prostate surgery
- Shoulder/rotator cuff
- Other:

Do you have allergies to any medication?

- No
- Yes (Please List)

Do you have any contact, food or dye allergies?

- No
- Yes (Please List)

Are you taking medications, including pain medication?

- No
- Yes (list with dosages)

Which of the following conditions have your family members had?

- Blood clots
- Cancer
- Diabetes
- Endocrine disorders
- Heart disease
- Neurologic conditions
- Neuropathy
- Stroke
- Other:

Do you currently smoke cigarettes?

- No, never
- No, I quit (when) _____
- Yes: ¼ ½ ¾ 1 1½ 2 3 packs per day

Do you currently consume alcoholic beverages?

- No
- Rarely
- Monthly
- Weekly
- Daily

Do you currently consume caffeinated beverages?

- No
- Rarely
- 1-2 drinks daily
- More than 2 drinks daily

How much exercise do you get on a regular basis?

- None
- Weekly
- 2-5 times per week
- Daily
- Competitive athlete
- Professional /elite

Occupation:

- Unemployed
- Homemaker
- Retired

- Student
- Permanently disabled
- Temporarily disabled since: _____ (date)

- Employed part time
- Employed full time

Employer: _____

Job title/description: _____

Education:

- Did not complete grade school
- Completed grade school
- Completed some high school

- Currently in high school
- G.E.D.
- High school graduate
- Completed some college
- Currently in college

- Trade school graduate
- College graduate
- Professional school graduate

Describe your level of stress:

- None
- Low

- Medium
- High

- Very high

Have you had any of the following symptoms or conditions?

- Abdominal pain/heartburn
- Chronic pain
- Difficulty swallowing
- General fatigue
- Hearing impairment

- Impaired coordination
- Impaired sexual function
- Impaired sleep patterns
- Loss of bladder/bowel control
- Vision/balance changes

- Weakness
- Weight gain
- Weight loss

Please add any other comments:

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____