

# CONSULTATION QUESTIONNAIRE



DATE \_\_\_\_\_

Patient First Name \_\_\_\_\_ Patient Last Name \_\_\_\_\_

1. What is your major symptom? \_\_\_\_\_
2. What does this prevent you from doing or enjoying? \_\_\_\_\_
3. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_  
Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_  
If yes, when and how? \_\_\_\_\_
4. How frequent is the condition? Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only \_\_\_  
How long does it last? All Day \_\_\_ Few Hours \_\_\_ Minutes \_\_\_
5. Are there any other conditions or symptoms that may be related to your major symptom?  
Yes \_\_\_ No \_\_\_. If yes, describe: \_\_\_\_\_  
Are there other unrelated health problems? Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
6. Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_  
Burning \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_
7. Is there anything you can do to relieve the problem? Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_  
\_\_\_\_\_
8. What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_  
Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_
9. List any major accidents you have had other than those that might be mentioned above:  
\_\_\_\_\_
10. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_ No \_\_\_ Uncertain \_\_\_
11. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_