New Problem Questionnaire

Please Print Clearly

What is the nature of the problem you would like to address?

_____

_____

How did the problem begin? (Circle one) **Gradually** **Suddenly**

How long have you had the problem for? _____ Days Weeks Months Years

What caused the problem?

_____

_____

_____

Have you had X-rays or MRI for this problem? **Yes** **No** If yes, where/when?

What makes it feel better?

What makes it feel worse?

How has this problem affected your daily life?

Have you seen another doctor or received treatment for this problem? **Yes** **No**
If yes, list the name of the doctor and what type of treatment/results?

_____

_____

Is there any other information that you feel will be helpful on your visit?

What are your goals and expectations for treatment?

I have provided this information truthfully and to the best of my knowledge.

_____ _____

Name Date