Michels Spinal Rehab Associates
Out of injury, back to life

New Patient Complaint Questionnaire

Welcome to our office!! Please fill out this questionnaire to help Dr. Michels determine your proper diagnosis and treatment plan.

Name:_____ **Date:**_____

CHIEF COMPLAINT / REASON FOR THIS APPOINTMENT:_____

_____

How long have you had this complaint?_____

Have you had **similar symptoms before**? ___Yes ____No If yes, when?_____

Does this pain **radiate to arms or legs**? ___Yes ____No If yes, describe:_____

Are symptoms generally: _____Improving _____Getting Worse ____About the same _____Intermittent

Have you **lost time from work**? ___Yes ____No If yes, **what dates**?_____

Date **returned to work**?_____ Dr. ordered? ____Yes ____No Self determined? ___Yes ___No

Effect on **daily activities**?____No effect ____Extra effort required _____Occasional limitation

____Frequent or severe limitations

What **treatment** have you **already had** for these conditions?:_____

_____

Is this condition **due to** a: _____Auto Accident _____Work Injury _____Other accident _____Illness

____Unknown Cause _____Other

Additional problems or concerns you would like to address today:_____

_____

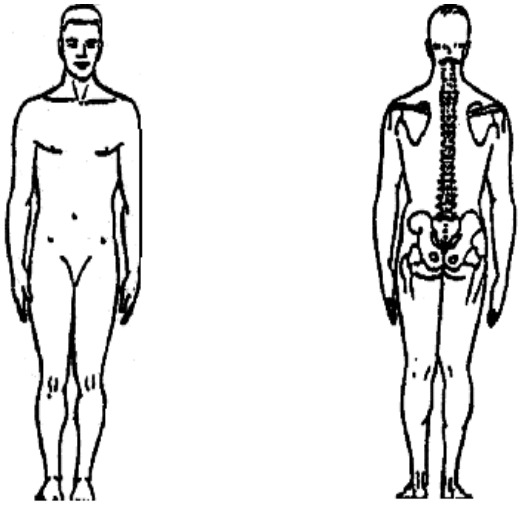
PAIN DRAWING

Please be sure to fill this out with extreme accuracy. Mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiating pain and include all affected areas. You may draw on the face as well.

Numbness = - - - - - Pins & Needles = OOOO

Burning Pain = XXXX Stabbing Pain = / / / / /

Aching Pain = (((((



PLEASE CIRCLE YOUR CURRENT PAIN/DISABILITY LEVEL

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable/Emergency Room**

How often are your symptoms present?	❑ Constantly	❑ Frequently	❑ Occasionally	❑ Intermittently
Describe your **current** pain/symptoms:	❑ Sharp/Stabbing ❑ Dull ❑ Numbness ❑ Burning	❑ Throbbing ❑ Soreness ❑ Shooting ❑ Tingling	❑ Aches ❑ Weakness ❑ Gripping ❑ Other: _____	
What makes the problem **better**?	❑ Nothing ❑ Standing ❑ Exercise	❑ Walking ❑ Sitting ❑ Inactivity/ Rest	❑ Lying down ❑ Movement ❑ Other: _____	
What makes the problem **worse**?	❑ Nothing ❑ Standing ❑ Exercise	❑ Walking ❑ Sitting ❑ Inactivity/ Rest	❑ Lying down ❑ Movement ❑ Other: _____	
Do you exercise?	❑ Yes, almost daily	❑ Yes, occasionally	❑ Not at all	
Describe your job requirements:	❑ Mainly sitting	❑ Light Labor	❑ Heavy Labor	
Describe your stress level:	❑ None to mild	❑ Moderate	❑ High	

Who is your **family physician**?_____ Location:_____

Have you seen any **other specialists**?_____Location:_____

Have you ever seen: _____Chiropractor? _____Acupuncture? _____Massage Therapist? If yes, who:_____

_____

Have you had any **other accidents / injuries** in the past? If yes, please describe:_____

_____

Other illnesses?_____

Doctor's Comments:_____

_____

_____

_____

_____

_____

_____

Patient Signature **Date**

For Office Use Only:

_____**Height** _____**Weight** _____/_____**Blood Pressure** **Handedness** **Left / Right**