

**FLORIDA ORTHOPAEDIC INSTITUTE**  
**DAVID A. REINA, D.C.**  
**PATIENT QUESTIONNAIRE**  
**INITIAL EVALUATION**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

MR # \_\_\_\_\_

Family/Primary Physician: \_\_\_\_\_

Family/Primary Physician Address and # \_\_\_\_\_

Who referred you to Dr. Reina:

- 1) Patient \_\_\_\_\_
- 2) Doctor \_\_\_\_\_
- 3) Friend \_\_\_\_\_
- 4) Advertising \_\_\_\_\_
- 5) Other \_\_\_\_\_

Age: \_\_\_\_\_

Marital Status: Single    Married    Divorced    Widowed

Sex:            Male    Female

Handed:        Right    Left    Both

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Current work status: (41)

- 1) Employed
- 2) Retired
- 3) Not Working
- 4) Light Duty

What are you seeing the doctor for? HEADACHE    NECK    BACK    OTHER \_\_\_\_\_

Have you seen a doctor in the past for your injuries/conditions?    YES            NO

Doctor/ Therapist	DATE	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



**ANY PAST ACCIDENTS OR INJURIES:**

**STATUS:** AUTO WORK FALL SPORTS HOUSEHOLD

DATE:	STATUS:	INJURY	TREATMENT
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

**CHIEF COMPLAINTS:**

**HEADACHES:**

Are you suffering from headaches? (50)

- a. NO
- b. YES, in the forehead on the Right Left \_\_\_\_\_
- c. YES, in the back of the head on the Right Left \_\_\_\_\_
- d. YES, on the side(s) Right Left \_\_\_\_\_
- e. YES, into the eyes Right Left \_\_\_\_\_
- f. YES, appears to be coming from the neck on Right Left \_\_\_\_\_

When did the headaches begin? You may circle more than one item. (51)\*\*\*

- a. After my accident of \_\_\_\_\_
- b. Years ago \_\_\_\_\_
- c. Within the past few weeks / months/ years \_\_\_\_\_
- d. Within the past few days \_\_\_\_\_

How many **times a week** do you have a headache? A migraine? (51)\*\*\*

- a. 1-2 \_\_\_\_\_
- b. 3-4 \_\_\_\_\_
- c. 4-6 \_\_\_\_\_
- d. Daily \_\_\_\_\_

How long do they last per episode? (51)\*\*\*

- a. 1-2 hours
- b. 3-4 hours
- c. 4-6 hours
- d. All day long \_\_\_\_\_

**Describe** your headache:

- 1. Severe    2. Debilitating    3. Deep pressure    4. Dull ache    5. Throbbing    6. Sick / Nauseating
- 7. Moderate    8. Mild    9. Sharp / Piercing    10. Blind spots that twinkle    11. Dizziness / Imbalance
- 12. No History of headaches and this is the worst head pain in your life.
- 13. Vision has changed \_\_\_\_\_

What makes your headaches **worse**? (52)\*\*

- a. Noise
- b. Light
- c. Food
- d. Motion
- e. Other \_\_\_\_\_

What makes your headaches feel **better**?

- a. Medication
- b. Massage
- c. Cold
- d. Heat
- e. Adjustments
- f. Other \_\_\_\_\_

Have you ever had a history of headaches or treated for headaches?        NO        YES       

Have you ever suffered a concussion? (53)        NO        YES       

Have you ever been treated for epilepsy?        NO        YES

## NECK PAINS

Do you have neck pain? (54)

- a. NO
- b. YES, in the back of the neck on the                      Right    Left \_\_\_\_\_
- c. YES, in the front of the neck on the                      Right    Left \_\_\_\_\_
- d. YES, on the side(s) of the neck on the                      Right    Left \_\_\_\_\_
- e. YES, coming from the shoulders on the                      Right    Left \_\_\_\_\_

Pain in the neck **began:** (55)

- a. After my accident on \_\_\_\_\_
- b. Years ago \_\_\_\_\_
- c. A few days / weeks / months ago \_\_\_\_\_
- d. I have always had some neck pain / restriction / stiffness \_\_\_\_\_

Have you ever had this type of pain or problem with your neck in the past: (56)

- a. NO \_\_\_\_\_
- b. YES \_\_\_\_\_

Have you ever been treated for a condition or problem with or arising from your neck?

- a. NO \_\_\_\_\_
- b. YES \_\_\_\_\_

Pain in Neck is:

- a. Constant
- b. Intermittent (comes and goes)

**Describe** your neck pain and condition: (57)\*\*

- a. Sharp
- b. Burning
- c. Dull ache
- d. Spasm
- e. Electricity / Shock
- f. Nauseating
- g. Weak and not stable

Pain intensity is:

- a. Mild
- b. Moderate
- c. Severe
- d. Can vary \_\_\_\_\_

Radiating pain is \_\_\_\_\_: (58)

- a. **Not** occurring into the arms or hand
- b. **Is occurring** into the arm and hand on the:                      Right    Left \_\_\_\_\_

Neck pain is made **worse** with: (59)\*\*

- a. Flexing the head down
- b. Extending the head back
- c. Rotating the head                      Right    Left
- d. Tilting the head                      Right    Left
- e. Coughing, Sneezing, Straining
- f. Other \_\_\_\_\_

Neck pain is made better with:

- a. Coldness
- b. Heat
- c. Massage
- d. Medication
- e. Motion
- f. Adjustments
- g. Other \_\_\_\_\_

## LOWER BACK

Do you have lower back pain? (60)

- a. NO
- b. YES, Centrally
- c. YES, on the right side of the lower back Right side into the hip? \_\_\_\_\_
- d. YES, on the left side of the lower back? Left side into the hip? \_\_\_\_\_
- e. YES, on both sides of the lower back? Both hips? \_\_\_\_\_

Have you ever had this type of pain or problem with your back in the past: (56)

- a. NO \_\_\_\_\_
- b. YES \_\_\_\_\_

Have you ever been treated for a condition or problem with or arising from your back?

- a. NO \_\_\_\_\_
- b. YES \_\_\_\_\_

Lower back pain began: (61)

- a. After my accident on \_\_\_\_\_
- b. Years ago (date) \_\_\_\_\_
- c. \_\_\_\_\_ days / \_\_\_\_\_ weeks / \_\_\_\_\_ months ago \_\_\_\_\_

Describe your lower back pain. (62)

- a. Deep dull \_\_\_\_\_
- b. Sharp \_\_\_\_\_
- c. Burning and/or electricity \_\_\_\_\_
- d. Hot and/or tingling \_\_\_\_\_
- e. Stiff and sore \_\_\_\_\_

Lower back pain is made worse with: (63)\*\*

- a. Flexion
- b. Extension
- c. Rotating Left / Right
- d. Side bend Left / Right
- e. Coughing, sneezing, straining
- f. Other \_\_\_\_\_

Lower back pain is made better with:

- a. Coldness
- b. Heat
- c. Massage
- d. Exercise and stretching
- e. Rest
- f. Other \_\_\_\_\_

Pain in the lower back is: (64)\*\*

- a. Constant
- b. Intermittent (comes and goes)

Lower back pain is:

- a. Mild
- b. Moderate
- c. Severe
- d. Varies

Lower back pain is: (65)

- a. Local and **DOES NOT radiate** into the legs and feet.
- b. **IS radiating** into the RIGHT / LEFT leg and/or RIGHT / LEFT foot \_\_\_\_\_

Bladder function is \_\_\_\_ (66)

- a. Normal
- b. Abnormal with: \_\_\_Increased frequency to urinate \_\_\_Decreased frequency \_\_\_Difficult to hold / control  
(Onset of condition) \_\_\_\_\_

Bowel Function is \_\_\_\_ (67)

- a. Normal
- b. Abnormal with: \_\_\_Constipation \_\_\_Diarrhea \_\_\_Both \_\_\_Control Difficulties  
(Onset of condition) \_\_\_\_\_

**ANY OTHER PAINS**

- 1. Fingers      RIGHT      LEFT \_\_\_\_\_
- 2. Wrist        RIGHT      LEFT \_\_\_\_\_
- 3. Hips         RIGHT      LEFT \_\_\_\_\_
- 4. Knees        RIGHT      LEFT \_\_\_\_\_
- 5. Ankles       RIGHT      LEFT \_\_\_\_\_
- 6. Toes         RIGHT      LEFT \_\_\_\_\_
- 7. Other \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:**

Circle any of the medical problems listed below that you have ever had: (68)

- |                                       |                           |
|---------------------------------------|---------------------------|
| (A) I have no known medical problems. | (L) Tuberculosis          |
| (B) Hypertension                      | (M) Liver disease         |
| (C) Coronary artery disease           | (N) Seizure disorder      |
| (D) Peripheral vascular disease       | (O) Thyroid disease       |
| (E) Adult onset diabetes              | (P) Emphysema             |
| (F) Childhood onset diabetes          | (Q) COPD/Lung problem     |
| (G) Past heart attack                 | (R) Immune disorder       |
| (H) Asthma                            | (S) Overweight            |
| (I) Ulcers                            | (T) Osteomyelitis         |
| (J) Hepatitis A / B / C               | (U) Osteoporosis          |
| (K) Cancer                            | (V) Other (specify) _____ |

Have you ever had: (71)

- (A) A blood clot
- (B) A blood transfusion \_\_\_\_\_ year?
- (C) Any previous broken bones \_\_\_\_\_
- (D) None of the above

How much alcohol do you consume? (69)

- |                                |                                      |
|--------------------------------|--------------------------------------|
| (A) I'm a non-drinker          | (E) An average of 1-2 drinks per day |
| (B) I'm a recovering alcoholic | (F) An average of 2-3 drinks per day |
| (C) I drink only occasionally  | (G) An average of 3-4 drinks per day |
| (D) I drink weekends only      | (H) More than 6 drinks a day         |

Do you now, or have you ever smoked cigarettes?

- (A) Yes, I am currently a smoker. I smoke (circle one) 1 2 3 \_\_\_\_\_ packs/day  
I have smoked for \_\_\_\_\_ years
- (B) No, but I used to smoke I smoked for \_\_\_\_\_ years
- (C) No, I have never smoked

Do you now, or have you ever used drugs? (70)

- |                  |                            |
|------------------|----------------------------|
| (A) NO           | (D) Marijuana              |
| (B) Recreational | (E) Other (Specify): _____ |
| (C) Cocaine      |                            |

**PAST SURGERIES:**

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

- |                                |                              |
|--------------------------------|------------------------------|
| (A) No previous surgeries      | (G) Hysterectomy _____       |
| (B) Appendectomy _____         | (H) Lumber laminectomy _____ |
| (C) Cataract extraction _____  | (I) Mastectomy _____         |
| (D) By-pass / open heart _____ | (J) Tonsillectomy _____      |
| (E) Gall bladder _____         | (K) Prostate surgery _____   |
| (F) Hernia repair _____        | (L) Other (Specify): _____   |

**REVIEW OF SYSTEMS:**

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle YES or NO.

SYMPTOMS			COMMENTS
Chest Pain	Yes	No	_____
Dizziness	Yes	No	_____
Dry cough	Yes	No	_____
Productive cough	Yes	No	_____
Difficulty breathing	Yes	No	_____
Irregular heartbeat	Yes	No	_____
Swelling in the legs	Yes	No	_____
Lack of appetite	Yes	No	_____
Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Diarrhea	Yes	No	_____
Constipation	Yes	No	_____
Abdominal cramping	Yes	No	_____
Varicose veins	Yes	No	_____
Bruising	Yes	No	_____
Bleeding	Yes	No	_____
Nose bleeds	Yes	No	_____
Joint pain and/or stiffness	Yes	No	_____
Muscle pain or muscle cramps	Yes	No	_____
Difficulty seeing	Yes	No	_____
Difficulty hearing	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Difficulty sleeping	Yes	No	_____

**What medications are you currently taking?** Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day
_____		
_____		
_____		
_____		
_____		
_____		

**Side effects to anti-inflammatory medications:**      **NONE**                      **YES**

Medication	Reaction
_____	_____
_____	_____
_____	_____

**ALLERGIES:**

Circle anything listed below to which you are allergic:

- |                        |                            |
|------------------------|----------------------------|
| (A) No known allergies | (G) Codeine                |
| (B) Penicillin         | (H) Iodine/Betadine        |
| (C) Tetracycline       | (I) Radiographic Dyes      |
| (D) Sulfa              | (J) Adhesive Tape          |
| (E) Morphine           | (K) Other (Specify): _____ |
| (F) Erythromycin       |                            |

**FAMILY HISTORY:**

Has anyone in your immediate family ever had any of the following? Circle the illness that apply. (31)

- |                             |                            |
|-----------------------------|----------------------------|
| (A) None known              | (I) Hypothyroidism         |
| (B) Cancer                  | (J) Colitis                |
| (C) Leukemia                | (K) Bleeding tendency      |
| (D) Stroke                  | (L) Asthma                 |
| (E) Hypertension            | (M) Tuberculosis           |
| (F) Coronary artery disease | (N) Seizure disorder       |
| (G) Rheumatic fever         | (O) Alcoholism             |
| (H) Diabetes                | (P) Other (Specify): _____ |

Would you be interested in taking part in a research study?

- a. No
- b. Yes

Everything I have answered is true and correct to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.  
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD  
AT FLORIDA ORTHOPAEDIC INSTITUTE