

Dr. Stuart Freedman

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PATIENT QUESTIONNAIRE

PERSONAL INFORMATION

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Sex M F Age _____ Birth date _____ Do you have health insurance? Y N

Occupation/Employer _____

E-Mail Address _____

Cell phone # _____ Home phone # _____ Work phone # _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Cell phone # _____ Work phone # _____

CURRENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the pictures where you continue to have pain/symptoms.

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

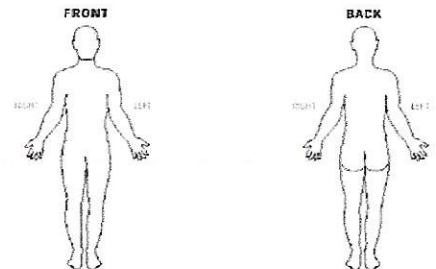
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or Movements that are painful to perform: Sitting Sleeping Walking Bending Lying Down



HEALTH HISTORY

What treatment(s) have you already received for your condition? _____

Name of doctor(s) who have treated you for your condition _____

Place an "X" to indicate if you have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Syndrome | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping Cough |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other (describe below) |

Describe any falls, head injuries, broken bones, dislocations, and surgeries you have had (with approx. dates):

List current medications:
