



Paul S. Goodkin DC PA
4750 N Federal Highway
Suite 203
Ft Lauderdale, FL 33308
P (954) 202-9009
F (954) 776-9953

PATIENT HISTORY QUESTIONNAIRE

Please answer the following questions briefly:

Reason for Visit: _____

When did symptoms appear: _____

How did it happen?

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

What makes the pain worse (aggravates)? _____

What improves the pain? _____

How often do you have the pain? _____

Does the pain radiate? _____ **If so, where does it radiate?** _____

What treatment have you already received for your condition? _____

Does the pain interfere with (circle): Work Sleep Recreation Daily Routine

The pain is (circle): Sharp Dull Throbbing Shooting Aching Burning Tingling Stiff

Is it painful to (circle): Sit Stand Walk Bend Lie Down Exercise

Are you presently under a doctors care? Yes _____ No _____

Have you ever been treated for the same condition? Yes _____ No _____

Do you: Smoke: Yes _____ No _____ Use Alcohol: Yes _____ No _____

Do you have high blood pressure? Yes _____ No _____

Do you have a heart condition? Yes _____ No _____

Do you have any form of cancer? Yes _____ No _____

Do you have a history of Diabetes? Yes _____ No _____

Describe any surgeries you have had: _____

Describe any hospitalizations: _____

Describe any traumas: _____

Describe any infections: _____

List any medications you are currently taking: _____

List any Allergies you have: _____