

Patient Questionnaire

Examiner: Morgan Rovetti, DC • David Rovetti, DC

Name: _____ Height: _____ Weight: _____ Age: _____

Briefly describe the problems you are experiencing (if any) with the following:

Self care or personal hygiene such as bathing, grooming, brushing teeth, dressing, eating, or going to the bathroom:

Communication such as hearing, speaking, reading, writing, or typing:

Physical activity such as sitting, standing, walking, bending, twisting, or climbing stairs. Also, any functional activities such as carrying, lifting, pushing, or exercising:

Sensory function such as hearing, seeing, smelling, feeling (including any numbness), tasting or smelling including foot, leg, arm or hand numbness:

Continued...

Hand function such as grasping, holding, gripping, pinching, or sensory discrimination:

Travel such as riding, driving, traveling by airplane, train or car:

Sexual function such as participating in desired sexual activity:

Sleep such as having a restful sleep pattern:

Which of the following tests do you remember having (because of this injury):

- X-rays
- MRI
- EMG or Nerve Conduction Studies
- Second Opinion Examination or IME
- Blood or Laboratory tests
- Functional Capacity Evaluation (FCE)

What are your current chief complaints/concerns in order of importance or severity?

Worst Complaint: _____

Second worst complaint: _____

Third worst complaint: _____

Other: _____

Briefly describe your symptoms: _____

Regarding your condition over the last three months:

- Got a lot worse
- Got a lot better
- Got a little worse
- Got a little better
- Not changed much

If it is changing, describe how: _____

Have you ever had any prior injuries to the body part(s) being examined today? No Yes

Right before this work injury, were you having any pain in or dysfunction of any of the injured body parts? No Yes

Do you believe there is any additional treatment that may benefit your condition? No Yes

(Optional) Overall, how would you describe the **medical care** you received:

- Excellent
- Good
- Fair/Adequate
- Poor
- Very Poor
- Insufficient
- Other: _____

(Optional) Overall, how would you describe the **administration of your claim** within the worker's compensation system?

- Excellent
- Good
- Fair
- Poor
- Very Poor
- Other: _____

I certify that the above is true and correct to the best of my knowledge. I understand that today's visit is for an evaluation only and no doctor-patient relationship will exist between Dr. Rovetti and me. I understand and allow Dr. Rovetti to release or obtain information regarding my current or past medical history, including this examination, to/from other health care providers, my previous or past employers, insurance companies, managed care organizations, TPA's, or governmental agencies.

Patient's Signature

Date

Home/Cell Phone: _____

Would you like to receive Health Update Newsletters from Dr. Rovetti? If yes, email: _____

Neck or Back Questionnaire

Please complete the following only if your condition involved a neck or back injury:

Have you ever had any prior back or neck problems or surgeries prior to your work injury? No Yes
If yes, describe problems and give dates if possible:

What exercises do you now usually do to stay physically fit or "in shape"? _____

How long at one time without a break can you do the following without serious discomfort?

Sit: (at one time): _____

Stand: (at one time): _____

Walk: (at one time): _____

How many pounds can you lift (approximately):

At frequent intervals: _____ Occasionally: _____

Regarding your back or neck:

How often do you have:

	Never	Rarely	Occasionally	Often	Constantly	Don't Know
No Pain						
Mild Pain						
Moderate Pain						
Severe Pain						

Describe any arm or leg numbness (if present):

Injured Worker's Signature *Date*