Patient Questionnaire

Examiner: 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:

Continued...

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

- ☐ X-rays
- ☐ MRI
- ☐ EMG or Nerve Conduction Studies
- ☐ Myelogram
- ☐ Blood or Laboratory tests
- ☐ Functional Capacity Evaluation (FCE)

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

1._____

2._____

3._____

_____

Briefly describe your symptoms:_____

_____

How long have your symptoms been the same (when did you begin feeling about as good as you do now)?

_____ ☐ months ☐ years

If they are changing, describe how:_____

_____

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 this visit today 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.

_____ Home Phone:_____

Patient's Signature *Date*

Neck or Back Questionnaire

Please complete the following only if your condition involves neck or back problems:

Have you ever had any previous back or neck problems or surgeries prior to your work injury? _____
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*