RETURN VISIT PATIENT QUESTIONNAIRE-
For Dr Benoy Benny

Dear Patient:

Name: ___________________

Please complete this questionnaire before you come for your appointment. Be sure to call us as soon as possible if you cannot make your appointment. Thank you.

Section 1: Questions About Your Current Problem

1. Current date ? __________________________
2. When were you last seen?_____________________________
3. What are you being seen for?

____

____

4. Describe your current Pain? ____

____

5. Generally speaking, are your symptoms getting better, worse or the same**?** ______________

6. Circle the number between 0 and 10 to indicate your level of pain in this last week:

Worst this week (no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst possible pain)
Best this week (no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst possible pain)
Average this week (no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst possible pain)

Section 4:Treatment History

7. Please write all treatments you have received for this problem since the last visit:

□ Medication changes

____

____

□ Physical Therapy and/or Occupational Therapy. Where and Dates__________________________

What did they teach you to do?

____

____

____

□ Injections or Nerve Blocks. Where and Dates _____________________________________

Do you know what injections were done?

____

____

Surgery? If yes, what?

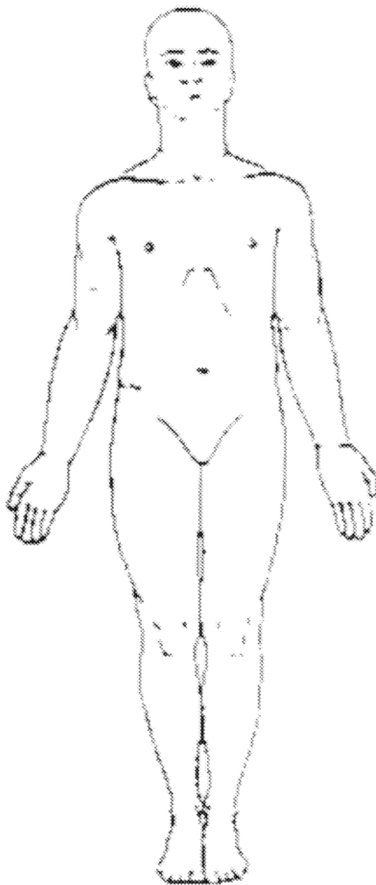
____

□ Manipulation or other chiropractic treatment
□ TENS
□ Psychological/Psychiatric Counseling
□ Acupuncture
□ Pain Program . Dates:_________________________
What did they do? ____
□ Massage
□ Homeopathic or other alternative medicine (please list): ________________________________

Section 3. Where is your pain located?

Mark the areas on the body where you feel the described sensations using the following markings:

Burning	□ □ □ □	Achiness	1 1 1 1
Numbness	- - - - - -	Pins/Needles	O O O O
Pain	x x x x	Stabbing	vvvvv



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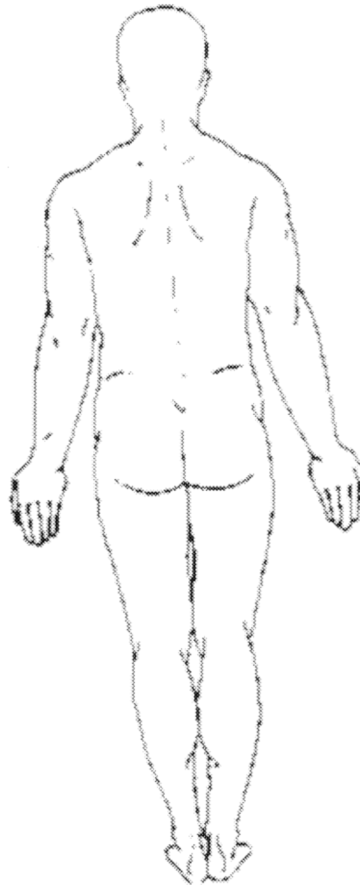

Back

Section 5: Functional Status:

□ yes □ no Do you have trouble getting to sleep because of pain. If yes please explain.

____

____

□ yes □ no Do you exercise? If yes, how often ____________________________________

Section 6: Please list all medications you **currently** take for **any reason** (including non-prescription drugs).

Drug Name	Dose	How Often	Pain meds only- - Does it help?
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

Please lists all known allergies:-____

Section 7: Please list any changes in Medical Health History or any recent hospitalizations or doctors visits:

____

____

____

Section 8: Review of Systems:

Check all that apply: □ None apply

- □ Reading glasses
- □ Change of Vision
- □ Loss of hearing
- □ Ear pain
- □ Hoarseness
- □ Nosebleeds
- □ Difficulty swallowing
- □ Morning cough
- □ Shortness of breath
- □ Fever or chills
- □ Heart or chest pain
- □ Abnormal heartbeat
- □ Swollen ankles
- □ Calf cramps w/walking
- □ Poor appetite
- □ Tooth ache
- □ Gum trouble
- □ Nausea or vomiting
- □ Stomach pain
- □ Ulcers
- □ Frequent belching
- □ Frequent diarrhea
- □ Frequent Constipation
- □ Hemorrhoids
- □ Frequent urination
- □ Burning on urination
- □ Difficulty starting urination
- □ Get up more than once every night to urinate
- □ Frequent headaches
- □ Blackouts
- □ Seizures
- □ Frequent rash
- □ Hot or cold spells
- □ Recent wt. change
- □ Nervous exhaustion

Women only

- □ Irregular periods
- □ Vaginal disch
- □ Freq. spotting
- □ Other ________________

____

____

How well are you sleeping?

____

____

*MD Initials and date*___________________

Weight: ___________________ Height: _______________________

Below is for Physician use only:

Vital signs: BP: _______/_________ HEART RATE: _________

Examination:

General:

HEENT:

Neurologic:

Sensation

Reflexes

others

MSK:

Inspection:

Strength

ROM

SPECIAL TESTS:

Other exam findings:

Assessment: (Please list objective findings if any)

Plan:

1.

2.

3.

Please send cc to referring physician and add address
Please add Physician name