

North Star Manual Therapy, Inc.
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Patient Questionnaire

(This information is kept confidential)

Name _____ Today's Date _____

Gender _____ Age _____ Physician _____

From whom did you hear about us? _____

Presenting problem and history of current condition _____

Please list any medical or health concerns _____

Please list all previous injuries, accidents, and any other pertinent medical information _____

Do you now have or have you had any of these symptoms in the past year?

Change in bowel movements _____ Persistent joint pain _____ Irritable bowel _____ Blood in bowel/urine _____

Hot flashes _____ Discharge from ears _____ Vertigo or dizziness _____ Persistent nose bleeds _____

Difficulty concentrating _____ Tiredness/fatigue _____ Muscle spasms _____ Learning disabilities _____

Fainting spells _____ Difficulty remembering _____ Eating disorder/difficulty _____ Other _____

Any history of:

Head or spinal injuries _____ Recurrent headaches _____ Meningitis _____ Stomach ulcers _____

Heartburn/indigestion _____ Shortness of breath _____ Anemia _____ Asthma _____

Bladder infection _____ Heart Problems _____ Depression _____ Suicide attempts _____

Other _____

Please list current meds: _____

Please list all allergies: _____

Any previous surgeries or scars? Please note year. _____

Have you had any other treatments for your current condition? (Ie PT, Chiropractic, Massage, Acupuncture) Please list practioners. _____

What has had a positive effect? _____

What has had a negative effect? _____

Have you been advised to have any surgery that has not been done? _____

Dental History: Who is your dentist? _____

_____ Ever wear braces _____ Ever wear a retainer _____ Grind or Clench your teeth _____

_____ Ever wear dental splint _____ Currently using a night guard _____ Dentures _____

_____ Any teeth pulled _____ History of TMJ _____

_____ Popping or clicking in jaw _____ Jaw ever lock up _____

Other: _____

Please describe your own birth (forceps, natural, C-section) _____

Have you ever been knocked unconscious? _____ concussions _____ Head/spinal injuries _____

dislocations _____

other _____

FOR WOMEN ONLY:

Please list number of:

_____ pregnancies _____ children _____ Miscarriages _____ Date of last pelvic exam _____ Date of last pap smear test:

negative or positive

Please check all that apply:

_____ Menstrual cycle irregular _____ Pass blood clots

_____ Pain and cramping during period _____ Pain with intercourse

_____ Take birth control? How long? _____

Any other information about pregnancies, complications with delivery, menstrual problems? _____

Any special tests that have been performed, the body part tested, and the results: (ie X-ray, MRI, Cat Scan) _____
