New Patient Questionnaire

Name: ______________________________ **Date:** __________

1. What is your purpose or goal for seeking care today? ______________________________

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2. Why did you choose my office? ______________________________

3. Why did you choose alternative care over conventional medicine? ______________________________

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4. What are your expectations with regards to your care here? ______________________________

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5. How long have you had your health problem?

   ❒ Hours ❒ Days ❒ Weeks ❒ Months ❒ Years

6. When was the first time you experienced your problem?

   ❒ Birth – 5 yrs. ❒ 6 – 15 yrs. ❒ 16 – 25 yrs. ❒ 26 – 50 yrs. ❒ 50 yrs. – Above

7. What do you think caused your health problem? ______________________________

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8. Are there any past accidents or injuries that are related to your current condition? ❒ yes ❒ no
   If yes, what would they be? ______________________________

9. Describe how your health problem feels at its worst: ______________________________

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10. Is it getting better or worse since yesterday? ❒ Better ❒ Worse

over

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11. What is this problem preventing you from doing either partially or totally? ____________________

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12. Can you live without doing those activities? ❒ yes ❒ no

13. How important is it for you to get rid of this problem?
    - ❒ I can live with it
    - ❒ I **want** to get rid of it
    - ❒ I **have** to get rid of it
    - ❒ It's ruining my life

14. Do you really want to get healthy ? ❒ yes ❒ no ❒ Depends on what's involved

15. Are you ready to change what you've been doing in order to become healthy? ❒ yes ❒ no

16. Why should our office help you to get well ? ____________________

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17. Is there anything else related to your condition that I should be aware of? ❒ yes ❒ no
    If yes, what would that be? ____________________

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