

# PATIENT QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Here is a list of health problems that some people have. How much pain or discomfort or worry does each of these problems cause you?

Problem	A Lot	Some	None at All
1. Pain	_____	_____	_____
• Headaches	_____	_____	_____
• Chest	_____	_____	_____
• Abdominal	_____	_____	_____
• Pelvic	_____	_____	_____
• Back	_____	_____	_____
• Joints or muscles	_____	_____	_____
2. Menstrual problems	_____	_____	_____
3. Hearing or vision problems	_____	_____	_____
4. Nervous (stress/anxiety/depression)	_____	_____	_____
5. Abuse (physical or emotional)	_____	_____	_____
6. Coughing or breathing problems	_____	_____	_____
7. Sleeping problems	_____	_____	_____
8. Sexual concerns	_____	_____	_____
9. Urine problems	_____	_____	_____
10. Bowel problems	_____	_____	_____
11. Skin problems	_____	_____	_____
12. Worried about: yourself, children, family, birth defects, cancer	_____	_____	_____
13. Tired	_____	_____	_____
14. Medicines	_____	_____	_____
15. Eating problems: weight changes	_____	_____	_____
16. Life style: smoking, alcohol, drugs	_____	_____	_____

These answers may help us be of more help to you.  
What special concerns do you have today?

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