THE UNIVERSITY OF KANSAS HEALTH SYSTEM
ST. FRANCIS CAMPUS

The University of Kansas Health System St. Francis Campus
1700 SW 7th St.
Topeka, KS 66606

PATIENT PROBLEM QUESTIONNAIRE

NAME:______________________________ DATE:______________

1. What are we seeing you for today? ______________________________
2. Have you had x-rays of this area? __________ If yes, what facility? ______________________
3. Is this an injury? ❑ Yes ❑ No If yes, date of injury______________________

   If yes, where did injury occur? Please be specific______________________

   ____
4. Describe how injury or onset of symptoms occurred. Please be specific______________________

   ____
5. Use the appropriate symbols to mark areas we are seeing you for today

   NUMBNESS . . . PINS & NEEDLES ooo

   BURNING xxx STABBING ///

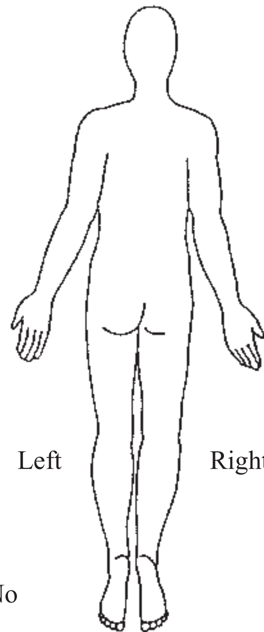
   ACHE ***

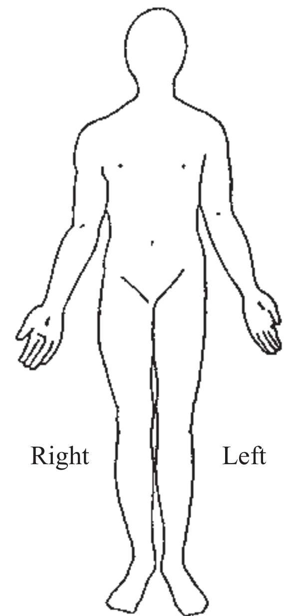
   On a scale from 1-10, rate your pain.
   1-slight - 10-unbearable__________

   Does your pain limit how far you can walk?
   Yes ________ No ________
   If yes, how far can you walk before the pain makes you stop? ______________

   Does your pain limit how long you can sit?
   Yes ________ No ________
   If yes, how long can you sit before the pain makes you get out of a chair? ____________

   Are you currently under a lot of stress?
   Yes ________ No ________





6. Have you had a previous injury to this area? ❑ Yes ❑ No

   If yes, please explain ______________________________

   ____
7. Have you missed work due to this problem? ❑ Yes ❑ No How many days? ______________

   Your job title ______________________________
8. Is there legal action pending related to your problem? ❑ Yes ❑ No
   If yes, attorney's name ______________________________
9. Have you been treated by another healthcare provider for this problem? ❑ Yes ❑ No
   If yes, name of provider(s) ______________________________
10. Please check any treatments or tests you have had for this problem prior to today's visit.
    ❑ Chiropractic ❑ Injections ❑ Surgery ❑ Physical Therapy ❑ MRI ❑ CT Scan ❑ Bone Scan
    ❑ Nerve Conduction Test ❑ Lab tests Where was the service provided?______________________

    ____

PATIENT SIGNATURE:______________________________ DATE: ______________

PATIENT INFORMATION