45 South Avenue West, Suite 101 • Cranford, NJ 07016
tel: 908-709-7300 • fax: 908-654-1062
WWW.PROSYNERGYPT.COM

PRE-EXAM QUESTIONNAIRE

Patient Name .... Date ....

1. Date of injury .... Date of surgery (if applicable) ....

2. Please describe your symptoms (how & when they started, aggravating & relieving factors, etc.)
....
....
....

3. How often do you experience your symptoms?
☐ constantly (100% of the day) ☐ frequently(25-75% of the day) ☐ intermittently(0-25%)

4. What describes the nature of your symptoms?
☐ sharp ☐ dull ☐ ache ☐ numb ☐ burning ☐ shooting ☐ tingling

5. How are your symptoms changing: ☐ getting better ☐ no change ☐ getting worse

6. What is your pain at this moment? (0 no pain, 10 worst imaginable pain)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. Who have you seen for your symptoms?
☐ Medical Doctor ☐ Chiropractor ☐ No One ☐ Other...

   What treatment did you receive?.....................................When? ....

8. What tests have you had? ☐ X-Rays, date: .... ☐ MRI, date: .... ☐ Other, date: ....

9. Have you had similar symptoms in the past? ☐ Yes ☐ No

10. In general your overall health right now is?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

11. Do you exercise regularly? ☐ Yes ☐ No

12. How would you consider your occupation? ☐ active ☐ sedentary

13. Do you smoke? ☐ No ☐ Yes - For how many years? ....

14. How much sleep do you get per night?...

continued

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Please check/circle if you have ever had, or do you presently have any of the following:

- ☐ Osteoporosis
- ☐ Bone, joint problems
- ☐ Arthritis / Rheumatism
- ☐ Allergies
- ☐ Back problems
- ☐ Breathing problems
- ☐ Broken bones, dislocations, sprains
- ☐ Cancer or tumor
- ☐ Skin disease or sores that don't heal
- ☐ Dizziness / Fainting
- ☐ Epilepsy / Seizure Disorder
- ☐ Fibromyalgia Syndrome
- ☐ Headaches / Migraines
- ☐ Head/Spinal Injury
- ☐ Heart Disease/Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other (explain) ....
- ☐ Pacemaker / Defibrillator
- ☐ Pregnancy (current)
- ☐ Hernia / Rupture
- ☐ Diabetes
- ☐ Stroke / Neurological history
- ☐ Swelling of feet or joints
- ☐ Surgeries

SURGERY / PROCEDURE: **DATE:**

1. ....

2 ....

3 ....

MEDICATIONS:

Are you allergic to any medications? ☐ No ☐ Yes - If yes, what?...

Are you currently taking any medications, please list below:

1.. 5. ....

2.. 6. ....

3.. 7. ....

4.. 8. ....

PATIENT SIGNATURE...**DATE** ....