Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Billing Questionnaire

Patient Name: _____ DOB: _____

Address: _____

City_____ State:_____ Zip_____

Phone #: Home_____ Mobile_____

Email address: _____

Employer Name:_____

Primary Care Physician/Clinic Name: _____

Phone: _____ Fax:_____

Address: _____

Spouse/Partner/Significant Other Name:

Emergency Contact Name (if not the same as above):
Emergency Contact Phone #:

Insurance Info: **BRING IN CARD TO PHOTOCOPY**

Guarantor's Name:
Guarantor's DOB:

Motor Vehicle Accident
Policy #:
Claims #:
Company, Agent Name, Phone number and email:

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Medical History Questionnaire

Name: _____

DOB:_____ Age: _____ Gender: M F

Occupation:_____

Referred by: _____

Primary Care Provider: _____

Other Practitioners (massage, chiropractor, acupuncturist, physicians):

_____

_____

_____

Are you: Right Handed Left Handed Ambidextrous

Why are you seeing the doctor today? _____

How long have you had this problem? (Date of Injury)_____

Is this a Workplace or Motor Vehicle Injury? Y N

Describe how the injury/accident occurred:_____

_____

If you are experiencing pain(s), where is it located?

_____

_____

Please rate the intensity of your pain/discomfort. (0=no pain, 10= severe pain). Indicate a range if your pain varies:

0 1 2 3 4 5 6 7 8 9 10

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Please circle a description(s) of your pain:

off and on	constant	dull	sharp	throbbing
tight	burning	tingling	cramping	aching

Is your pain worse at a particular time of the day?

Morning Daytime Night

In the affected area, do you have (If yes, please describe):

Stiffness	Y	N_____
Numbness	Y	N_____
Swelling	Y	N_____
Weakness	Y	N_____
Instability	Y	N_____
Apprehension	Y	N_____
Other	Y	N_____

What activities or movement makes your pain/discomfort worse?

_____

Please describe any other previous injury to the area in question.

_____

Have you tried any of the modalities below for this injury?

Medication	Y	N	Type:_____
Physical Therapy	Y	N	How long:_____
Injections	Y	N	Location of Injection:_____
Brace	Y	N	

Other (chiropractor, massage, acupuncture) Describe:

_____

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Past Medical History & Family History

	SELF	Mother	Father	Siblings	Grand-parents	Children
Alcoholism						
Alzheimer						
Arthritis						
Asthma/Lung Issues						
Bleeding Disorder						
Cancer(s)						
Depression/ Anxiety						
Diabetes						
Drug Abuse						
Epilepsy						
Glaucoma/Eye problems						
Heart Disease, attack,palpitations)						
High Cholesterol						
High Blood Pressure						
Intestinal Issues: IBS, stomach						
Kidney Disease						
Liver Disease: Hepatitis						
Migraines						
Thyroid Issues						
OTHER:						

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PAST SURGERY, HOSPITALIZATIONS, and/or ACCIDENTS:

Date	SURGERIES/Medical Issue
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS & SUPPLEMENTS:

Name	Dose	Frequency	Name	Dose	Frequency
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

ALLERGIES/SENSITIVITIES (please list):

_____ _____

_____ _____

SOCIAL:

Do you drink Alcohol? Y N How much?_____

Do you use Tobacco? Y N How much?_____

If you did in the past, when did you quit? _____

Do you follow a special Diet? Y N What type?_____

Do you exercise regularly? Y N How much?_____

Do you have any other Hobbies? Y N

What are they? _____

What is your height? _____ What is your weight? _____

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Do you have any of the following that haven't been addressed elsewhere? (circle all that apply)

Fever	Headaches	Head Injury
Double vision	Blurry vision	Issues w/ bright light
Hearing loss	Ringing of ears	Nose Bleeding
Nasal congestion	Dental issues	TMJ
Chest Pain	Palpitation	Chronic Cough
Wheezing	Shortness of Breath	Pain w/ deep breath
Nausea	Vomiting	Belly pain
Constipation	Loose Stools	Heartburn
Loss of appetite	Blood in Stool	Rash
Itching	Pain w/ urination	Impotence
Frequent urination	Irregular Menses	Increased thirst
Incontinence	Weight gain/loss	Trouble sleeping
Low desire to have sex	Brain Fog	Low Energy
Trouble with orgasm	Hair Loss	Brittle nails
Pain with sex	Temperature Intolerances	Hot Flashes
Vaginal Dryness	Heavy Period/Cramps	Bleeding Gums
Suicidal thoughts	Panic/Anxiety	Depression
Easy bruising	Leg or Feet Swelling	Chronic Infection

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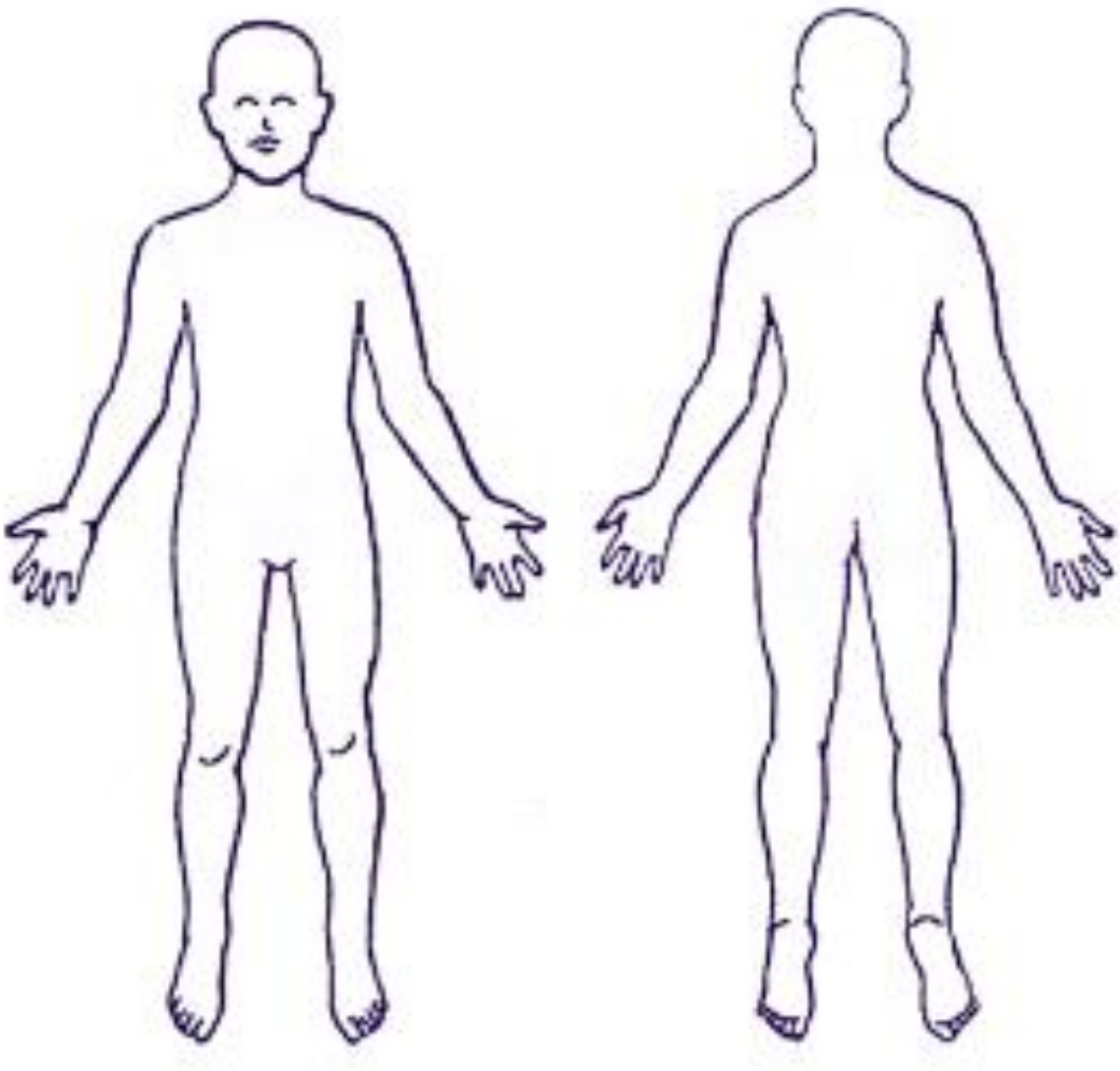

PLEASE INDICATE WHERE YOU ARE EXPERIENCING:

PAIN with an X

DISCOMFORT with ////

RADIATION of the pain or discomfort with #

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PLEASE SELECT THE ONE WORD ON EACH LINE (1-10) THAT BEST DESCRIBES YOU:
(Select only 1 word(s) in each of the 10 horizontal rows.)

1.	____DETERMINED	____CONVINCING	____PREDICTABLE	____CAUTIOUS
2.	____STRONG WILLED	____PERSUASIVE	____EASY-GOING	____ORDERLY
3.	____DIRECT	____EXPRESSIVE	____KIND	____ANALYTICAL
4.	____BOLD	____SOCIABLE	____COOPERATIVE	____PRECISE
5.	____OUTSPOKEN	____ANIMATED	____PATIENT	____LOGICAL
6.	____DECISIVE	____TALKATIVE	____LOYAL	____CONTROLLED
7.	____DARING	____OUT-GOING	____AGREEABLE	____CAREFUL
8.	____RESTLESS	____ENTHUSIASTIC	____CONSIDERATE	____THOROUGH
9.	____COMPETITIVE	____INSPIRING	____CONSISTENT	____DETAILED
10.	____AGGRESSIVE	____PLAYFUL	____SATISFIED	____ACCURATE

(updated 10/11/21)

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