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PATIENT QUESTIONNAIRE

(Please fill out all 5 pages)

Name: _____ Date: _____

Occupation: _____ Age: _____

Referred by: _____ Dominant Hand:

Primary Care MD: _____ ☐ Right ☐ Left

1. Main Problem: _____

   _____

2. Please describe symptoms: _____

   _____

3. When (roughly what date) did your present pain/problem start? _____
4. Are you still working? ☐ Yes ☐ No
5. How many years have you had your pain/problem? _____ year(s)
6. How frequently do you have aggravations per year? _____
7. Did your present pain start: ☐ Gradually ☐ Suddenly
   a. If suddenly, describe what provoked it _____
   b. If injury related, what kind: ☐ Auto Accident ☐ Work Injury ☐ Other
8. What makes the pain worse and what is your tolerance time for these activities?

☐ Sitting	☐ During exercise	☐ Looking up
☐ Coughing	☐ After exercise	☐ Looking Down
☐ Sneezing	☐ In the morning	☐ In the evening
☐ Bending forward	☐ Bending backwards	☐ At night
☐ Driving/riding in a car	☐ Twisting	☐ Walking
	☐ Standing	

9. What reduces pain? (describe) _____
10. Generally, how would you describe your current pain?

☐ Dull ache	☐ Burning	☐ Intermittent
☐ Sharp	☐ Shock like	☐ Constant
☐ Stabbing	☐ Pins and needles	☐ Deep boring pain
☐ Other _____		

11. Rate your pain intensity on a scale 0 – 10 (with 0 being no pain and 10 is the most severe pain you have ever experienced in your life, prompting you to go immediately to the ER.)

a. How bad is your pain now?	0	1	2	3	4	5	6	7	8	9	10
b. What is it when it is at its worst?	0	1	2	3	4	5	6	7	8	9	10
c. What is it when it is at its best?	0	1	2	3	4	5	6	7	8	9	10

12. If you have both back and leg pain: Back pain is _____% of your pain
Leg pain is _____% of your pain

13. If you have both neck and arm pain: Neck pain is _____% of your pain
Arrn pain is _____% of your pain

14. Have you recently or are you currently experiencing:

☐ Weakness in your ____ Arm(s) ____ Leg(s)
☐ Numbness/Tingling in your ____ Arm(s) ____ Leg(s)

15.. Which of the following describes your sleep as it relates to this problem:

☐ Difficulty getting to sleep
☐ Wake up during the night Because of the pain
☐ Wake up with pain when lying on the painful side
☐ Have no difficulty sleeping

16.. Overall, for this episode, are you now?

☐ Improving ☐ Worsening ☐ Staying the same

17.. Have you had any of these diagnostic studies for this problem?

			Date(s)
Diagnostic X-Rays	☐ Yes	☐ No	_____
MRI (Magnetic Resonance Imaging)	☐ Yes	☐ No	_____
Ct (Computed Tomography)	☐ Yes	☐ No	_____
EMG (Electromyography)	☐ Yes	☐ No	_____
Injections	☐ Yes	☐ No	_____
Epidural Injections, nerve block	☐ Yes	☐ No	_____
Discogram	☐ Yes	☐ No	_____
Arthrogram	☐ Yes	☐ No	_____
Radiofrequency ablation	☐ Yes	☐ No	_____
Rhizotomy	☐ Yes	☐ No	_____
Nucleoplasty	☐ Yes	☐ No	_____
Facet joint injections	☐ Yes	☐ No	_____

18.. Have you had surgery for this problem? ☐ Yes ☐ No

Type: _____ Date: _____

Change in condition after surgery: ☐ Better ☐ Worse ☐ Same

For _____ months / years

19. Since your pain/problem started, what type of treatment have you tried? (when, where, frequency, duration, effectiveness):

☐ Physical Therapy ☐ Traction ☐ Hypnosis
☐ Acupuncture ☐ Bio-feedback ☐ Massage
☐ Chiropractic ☐ Ultrasound ☐ TENS (e-stim)
☐ Heat/Ice ☐ Other _____

20..What pain medications have you taken over the past week?
Name:_____ Dose_____ # of tablets per day _____

21. What other types of Doctors or health care providers have you seen for this condition? _____

22. Do you have any difficulties controlling your bladder? ☐ Yes ☐ No
If yes, explain:_____

23. Do you have any difficulties controlling your bowel? ☐ Yes ☐ No
If yes, explain:_____

24. Is there any chance that you are pregnant at this time? ☐ Yes ☐ No

25 MEDICAL HISTORY

Have you been diagnosed with any of the following problems?

- ☐ Ulcer or gastrointestinal bleeding
- ☐ Diabetes mellitius: Date diagnosed _____ Insulin?_____
- ☐ High Blood Pressure
- ☐ Heart Disease/Prior Myocardial infraction
- ☐ Hepatitis: Which type? _____
- ☐ HIV ☐ Other
- ☐ Neurologic disease, including stroke, epilepsy, or transient ischemic attacks
- ☐ Chronic Lung Disease, including asthma, bronchitis, or emphysema
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Thyroid
- ☐ Migraines
- ☐ Cancer: What type?_____
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Osteoporosis
- ☐ Bleeding Disorder
- ☐ Other

26. What surgeries have you had in your life:?

Surgery	Year
_____	_____
_____	_____
_____	_____

27. Are you allergic to any medications: ☐ Yes ☐ No
if yes, which ones_____

28. Are you allergic to anesthetic agents (numbing medication) ☐ Yes ☐ No

29. Are you allergic to Iodine/Shellfish/X-Ray contrast or Dye? ☐ Yes ☐ No

30. If your are taking any medications, please list _____
_____
_____

31, Social History

a. Marital Status ☐ Married ☐ Single ☐ Divorced ☐Widow

a. Highest level of education completed?_____

b. Exercise Activity (type frequency) _____

c. Do you smoke ? ☐ Yes ☐ No

Packs per day _____ Number of years (present or past) _____

e Do you drink alcohol? ☐ Yes ☐ No

Average drinks per week _____

f Do you use recreational drugs? ☐ Yes ☐ No

Type_____ How much? _____

G Do you plan to continue your regular job? ☐ Yes ☐ No

32. Do any ofoyour immediate family members have any serious medical problems?

☐ Diabetes ☐ Muskuloskeletal Problems

☐ Cancer ☐ Other _____

☐ Heart Disease

33 Do you have any additional information that would be helpful in understanding your Problem?_____

_____

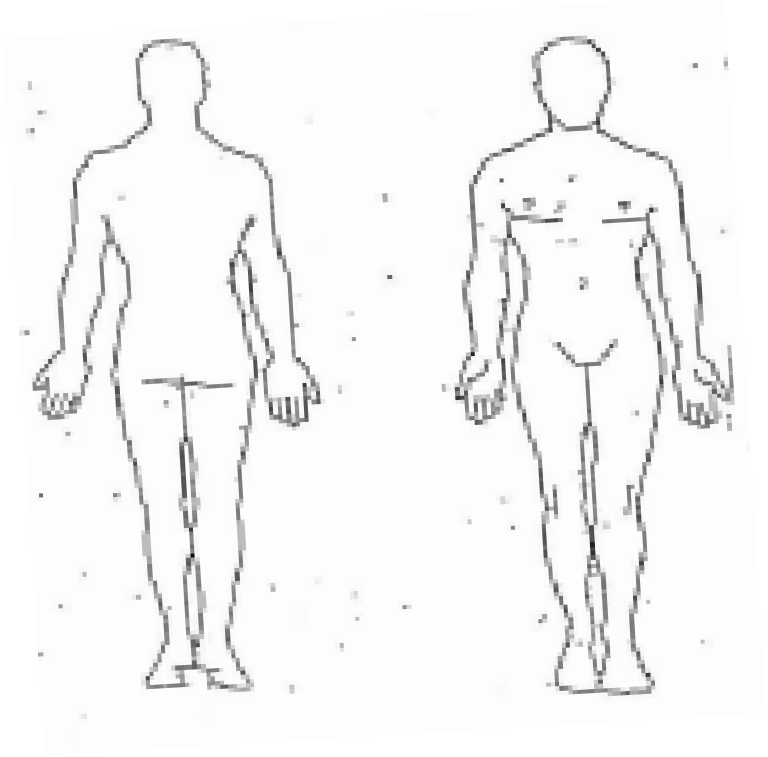
34 Are you interested in complementary, alternative, integrative treatments for your Problem (acupuncture, prolotherapy, supplements, etc) ☐ Yes ☐ No

35. Where is your pain? Please indicate on the diagram below the areas on you affected by the pain by marking the location(s) on the body outline below.

<u>Use the following key</u>

SSS – Stabbing

BBB – Burning
NNN – Numbness
AAA – Aching, cramping
PPP – Pins and needles
OOO – Other



General Survey of Body Systems

Circle any of the following symptoms you've previously experienced and/or are currently having. If you have none of the symptoms, circle "None Apply":

1. **Cardiovascular**: Any chest pain, palpitations, irregular heartbeats, high blood pressure, exercise intolerance? None Apply

2. **Endocrine**: Any excessive thirst or hunger, hyper/hypoactivity, sweating, fatigue? None Apply

3. **GI**: Any weight loss, indigestion, abdominal pain, diarrhea, constipation, loss of appetite, hernias, ulcers, jaundice, bloody stool? None Apply

4. **Head & Neck**: Any headaches, vision problems, double vision, eye pain, glaucoma, cataracts, hearing loss, ringing in ears, dizziness, sinusitis, hoarseness, voice change, goiter? None Apply

5. **Hematological/Lymphatic**: Any bleeding tendency, lymph node pain/enlargement, anemia, transfusion, easy bruising, unusual fatigue? None Apply

6. **Musculoskeletal**: Any loss of strength, muscle wasting, joint pain/ stiffness, osteoporosis, gout? None Apply

7. **Neurological**: Any headaches, loss of consciousness, seizures, loss of balance, loss of bowel/bladder control, loss of memory, stroke? None Apply

8. **Psych**: Any depression, mood swings, sleep disturbances, hallucinations? None Apply

9. **Reproductive Tract**: Any history of STD's, fertility problem, abnormal pap tests? None Apply

10. **Respiratory**: Any shortness of breath, asthma, coughs, wheezing? None Apply

11. **Skin**: Any rashes, itching, scars, lesions, masses, discoloration? None Apply

12. **Urinary Tract**: Any painful urination, incontinence, urinary infections, flank pain, kidney stones? None Apply

Are you being treated for any of the symptoms you circled? ☐ Yes ☐ No
If NO, we recommend you discuss with your primary care doctor.

Your signature: _____ **Date** _____