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PLEASE FILL OUT THIS QUESTIONNAIRE COMPLETELY. IT WILL HELP IN YOUR TREATMENT. THANK YOU!

Date: _____

Name: _____ Language Spoken: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Age: _____ Date of Birth: ____/____/____ Sex: M F Work Phone: _____

Who referred you here? _____

What Doctors have treated you for this pain? _____

Work status? _____ Occupation: _____ How long? _____

Is this pain related to: Injury (work, automobile, etc)? ____ Yes ____ No Illness? ____ Yes ____ No

Explain how: _____

If legally disabled, date last worked: _____

Do you have an Impairment Rating? _____ What Percentage? _____ % When was it done? _____

Are you now involved in a lawsuit or planning to sue anyone? ____ Yes ____ No

If yes: Name of Attorney? _____ Phone Number: _____

SOCIAL HISTORY

Marital Status: _____ Number of Children: _____ Ages: _____

Who lives with you? _____

How many years of school completed? _____

Do you smoke? (How much?) _____

Do you drink alcohol? (How much?) _____ Do you use drugs? _____

PAIN INFORMATION

How long have you had your pain? _____

Where is your pain? _____

PLEASE BRING ALL THE MEDICATIONS YOUR PRESENTLY TAKING WITH YOU TO THE EVALUATION

Circle the words that describe your pain:

Constant

Intermittent

Choose 4 or less Dull

Aching

Tingling

Numb

Sharp

Throbbing

Cramping

Burning

Cold

Shocking

How many hours do you sleep at night? _____ Do you wake up during the night because of pain? ____ Yes ____ No

Do you drive? _____

How do the following affect your pain? Better (B), Worse (W), or No Change (NC)

Standing _____ Lying Down _____ Being around people _____

Sitting _____ Heating Pad _____ Bright lights _____

Walking _____ Medications _____ Driving _____

Coughing/Sneezing _____ Massage _____ Eating _____

Physical activity _____ Alcoholic drinks _____ Loud Noises _____

Weather changes _____ Stress _____

Using the following Pain Scale answer the questions with the number that corresponds to the severity of your pain. On the scale from 0 to 10, 0 means no Pain and 10 means the worst severe pain you can imagine.

0	1	2	3	4	5	6	7	8	9	10
No Pain	minimal		mild	moderate		severe				worst imaginable

Does your pain vary in intensity? ____ Yes ____ No

The WORST pain you ever have (from 0 to 10) is _____ What is your pain level (from 0-10) now? _____

The LEAST pain you ever have (from 0 to 10) is _____ What is the pain level of a needle stick? _____

PREVIOUS TREATMENT AND RESULTS

Have you ever had surgery for your pain problem? ____ Yes ____ No When? _____

Treatments you have had for this pain condition

	Yes/No	Help (H) or No Help (NH)
Bed rest	_____	_____
Physical therapy / exercise	_____	_____
Medications	_____	_____
Epidural steroid injection	_____	_____
Chiropractic treatments	_____	_____
Biofeedback / hypnosis	_____	_____
Traction	_____	_____
Other	_____	_____

GENERAL MEDICAL HISTORY

ALLERGIES: List ALL allergies to MEDICINES and FOODS and what the reaction is: _____

MEDICINES: List all medicines that you have been taking. Include vitamins and non-prescription medicines as well as prescribed medicines. Indicate the amount you usually take in a day or a week.

Name	Dose	How often	Name	Dose	How Often
_____			_____		
_____			_____		
_____			_____		

List all the medicines you have tried in the past for pain: _____

Have you ever been hospitalized because of your PAIN? ____ Yes ____ No

When? Where? Why?

Are you presently taking ANY of these type of medicines? Yes / No

- Aspirin _____
- Blood thinners or anticoagulants _____
- Birth Control Pills _____
- Diet Pills _____
- Steroids _____

Do you or your family (mother, father, grandparents) have or had? Yes / No

- | | |
|----------------------------------|----------------------------------|
| Cancer _____ | Lung problems _____ |
| High blood pressure _____ | Kidney problems _____ |
| Heart problems _____ | Liver problems _____ |
| Diabetes or sugar problems _____ | Bleeding problems / Anemia _____ |
| Vascular problems _____ | Other _____ |

Surgeries

Year	Surgery	Reason / Doctor / Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have or have had any of the following? Yes / No

CONSTITUTIONAL

- Weight change
- Fatigue
- Fainting
- Headaches
- Dizziness

EYES

- Glaucoma
- Double Vision
- Vision problems

EARS, NOSE, MOUTH, THROAT

- Hearing problems
- Ringing in ears
- Ear aches
- Nose bleeds
- Sinus trouble
- Trouble swallowing
- Hoarseness

CARDIOVASCULAR

- Heart murmur / Palpitations
- Poor circulation
- Varicose veins
- Chest pain
- Leg / Foot swelling / pain

RESPIRATORY

- Cough
- Shortness of breath
- Wheezing
- Bronchitis
- Asthma

GASTROINTESTINAL

- Heartburn
- Vomiting of blood
- Ulcers
- Rectal bleeding
- Black tarry stools
- Constipation
- Diarrhea
- Jaundice / Hepatitis

GENITOURINARY

- Wake up to urinate at night
- Urinary incontinence
- Difficult or painful urination
- Urinary infections
- Discharge from penis
- Vaginal discharge

SKIN

- Rashes / texture changes
- Skin color changes
- Changes in hair or nails
- Breast lumps

HEMATOLOGIC

- Anemia
- Easy bleeding or bruising

NEUROLOGICAL

- Tingling
- Blackouts
- Seizures
- Paralysis

ENDOCRINE

- Impotence
- Heat or cold intolerance

Frequent urination

Excessive thirst

PSYCHIATRIC

- Depression
- Nervousness

X-RAY STUDIES: If you had any X-rays, please indicate the year and the result, if known:

X-rays / MRI / CT

Year

Result

Patient Signature

Date

Reviewed with patient: _____

Date