

Patient Questionnaire

Last, First, Middle Name _____ Today's Date _____

Age: _____ Birth Date: _____ Sex: Male Female Right or Left Handed: _____

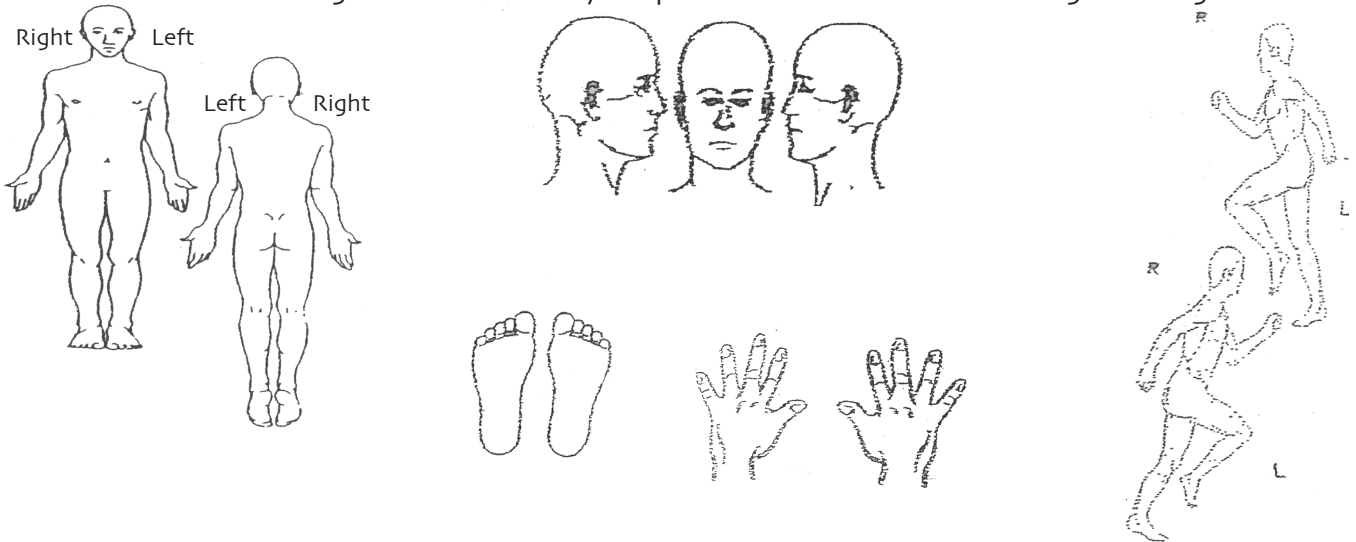
Where is your pain? _____

Referring Physician's Full Name: _____ Telephone: _____

Physician's Address _____

Why do you need to see a Pain Specialist?

Please mark an "X" on the figure below where your pain starts and show where it goes using an arrow:



How and when did your pain begin? _____ (Month/year)

- Work accident
- Home accident
- Auto accident
- Other _____
- Following surgery/illness
- Other accident
- Unknown

Describe the circumstances around the onset of your pain:

Please mark the area(s) on the diagram above in which you are in pain.

Circle the number that best describes how severe your pain is.



How often does the pain occur?

- Continuously
- Several times per day
- Intermittent
- Occasionally
- Less than daily

How do the following factors affect your pain? (check on blank per number)

	Better	Worse	No effect		Better	Worse	No effect
1. Heat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	6. Climate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Cold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	7. Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	8. Coughing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	9. Massage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	8. Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What makes your pain WORSE? (check on blank per number)

- Bending Coughing Standing a long time
 Lifting Sneezing Sitting a long time
 Defecation Sexual intercourse Other: (please specify) _____

In what position do you sleep? Lying on your back Lying on your side

Are there any other symptoms/problems associated with the pain?

- Difficulty sleeping Feeling "blue" all the time Difficulty with intercourse
 Intercourse is painful Other(s) please describe: _____

Yes No

- Do you have urge to move the legs at night or at rest?
 Do you have numbness in the legs or feet or discomfort?
 Do your symptoms worsen when you are lying down or resting?
 Do your symptoms worsen at night?
 Do you get relief with movement with walking or stretching?
 How many times do you wake up in the middle of the night?

What time do you go to bed and fall asleep? _____

What time do you wake up to do your morning routine? _____

TREATMENT HISTORY

(If you do not have back or low back pain, skip this section and go to the PAST MEDICAL HISTORY section)

1. Which of the following caregivers have you visited prior to your arrival here (please give names)

- _____
- Family physicians (includes general Practitioners, internists, gynecologists, etc.)
 Sports medicine Orthopedic surgeon Neurologist Rheumatologist
 Occupational medicine Anesthesiologist Rehabilitation medicine
 Other pain management _____
 Osteopathic physician Chiropractor Acupuncturist
 Alternative medicine Biofeedback

2. Which of the following test have you undergone prior to your arrival here today?

- X-rays CAT scan MRI scan EMG test
 Discogram Neural block Myelogram

3. Have you had any of the following interventions done for your neck or low back pain?

- TENS/ nerve stimulator Ultrasound Heat Cold Cryotherapy
If so how many times? 1 2 3 4 or more
 Trigger point injections
If so, how many times? 1 2 3 4 or more
 Facet injections Sacroiliac joint injections Other joint injections _____
 Discography

4. Have you ever had any of the following surgical interventions (for neck and back pain?)

- Disectomy done in (Yr) _____ Laminectomy done in (Yr) _____
 Temporary Spinal Cord Stimulator done in (Yr) _____
 Permanent Spinal Cord Stimulator done in (Yr) _____
 Lumbar or Sacral Cage/Hardware done in (Yr) _____
 Bed rest Lumbar traction Exercise Physical therapy
 Manipulations Mobilization Medications Prolotherapy
 Therapeutic injections of any kind Counseling Hypnosis Loss of work

REVIEW OF SYMPTOMS

If you currently have any of the following symptoms, please place a check mark on the one that applies:

- "Constitutional" Fever Weight loss Fatigue No problems
- Eye Problems Blurred vision Double vision Loss of vision
 Eye pain Eye redness Eye dryness No problems
- Ear/Nose/Throat Trouble hearing Ringing in ears Dizziness (vertigo)
 Loss of balance Ear pain Ear discharge No problems
- Cardiovascular Chest pain Irregular heart beat High blood pressure
 No problems Limb pain on walking Fainting
- Respiratory Indigestion Heart burn Abdominal pain Nausea
 Vomiting Regurgitation Diarrhea Constipation
 Bloody stools No problems
- Genitorurinary Incontinence Pain on urination Blood in urine No problems
- Musculoskeletal Muscle pain Muscle cramp Muscle twitches Loss of muscle bulk
 Neck pain Back pain Joint pain Joint stiffness
 Joint swelling No problems
- Skin & Breast Numbness Tingling Discoloration Hair loss
 Nail change Sweating change No problems
- Neurological Headache Face pain Face numbness Blackouts
 Weakness Tremors Seizures Trouble with memory
 Trouble concentrating No problems
- Psychiatric Hallucinations Feeling depressed Trouble sleeping
 Suicidal thoughts Inappropriate crying Inappropriate laughing
 No problems
- Hematological /Lymphatic Abnormal bleeding Anemia Lumps or swelling No problems
- Allergic / Immunologic Skin rash Joint pain Dry eyes &/ or Dry mouth No problems
- Endocrine Excessive rash Heat or cold intolerance Excessive urination

PAST MEDICAL HISTORY

Please list all, if any, DRUG ALLERGIES and their REACTIONS:

Please list all MEDICATIONS:

Do you take any of the following?

- Aspirin Coumadin Plavix Heparin Pletal Lovenox Ticlid

Previous Pain Medications: _____

- Use illegal drugs

CURRENT MEDICATIONS	DOSAGE	HOW OFTEN?
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Please list all MEDICAL PROBLEMS:

List all SURGERIES and their DATES:

SOCIAL HISTORY

Any use of tobacco (type and for how long)? _____

Any use of alcohol (type and for how long)? _____

Any use of recreational drugs (type and for how long)? _____

What type of work do you do? _____

Education: Grade School High School College Post-Graduate Vocational Training

Marital Status: _____

FAMILY HISTORY

Mother: Living Deceased Age _____ Health Issues: _____

Father: Living Deceased Age _____ Health Issues: _____

Brother(s): # _____ Living Deceased Age _____ Health Issues: _____

Sister(s): # _____ Living Deceased Age _____ Health Issues: _____