

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Occupation: _____ Date: _____

1. When (roughly what date) did your present pain start?

Are you still working?

Yes No Last day on job _____

2. How did pain start? (check appropriate box)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Suddenly | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Gradually | <input type="checkbox"/> Injured at work |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Injured in auto accident |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Hit from behind |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Injured during sports |
| <input type="checkbox"/> Bending | <input type="checkbox"/> No apparent cause |

3. What activities make the pain worse?

- | | |
|--|---|
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Bending forward |
| <input type="checkbox"/> Exercise (after) | <input type="checkbox"/> Bending backward |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Walking | |

4. What reduces the pain?

- | | |
|--|---|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Pain pills |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Injections for pain |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Muscle relaxant pills |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Aspirin or anti-inflammatory pills |
| <input type="checkbox"/> Manipulation | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Exercises in physical therapy | <input type="checkbox"/> Other |

5. How long have you had this pain?

_____ years _____ months _____ weeks

How long have you had similar pain?

_____ years _____ months _____ weeks

6. Have you had any of these diagnostic studies?

	Yes	No	Date
Diagnostic x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT (computed tomography) scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram (x-ray with dye injection)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electromyogram (EMG)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI (magnetic resonance imaging)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthrogram or sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____

7. Have you been hospitalized for your pain problem?

No Yes

Number of times _____ Dates _____

8. Have you had surgery for this problem? No Yes
Number of times _____ Dates _____

9. Have you been hospitalized for other medical problems?

No Yes

Number of Times _____ Describe _____

10. What medications are you currently taking? _____

11. Do you take antacids? Yes No

12. Do you have any of the following conditions?

- | | |
|--|---|
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Bowel or bladder problems | _____ |

13. Do you have allergies?

No Yes Please list: _____

14. Do you smoke?

No Yes How much? _____

15. Do you drink alcoholic beverages?

No Yes How much? _____

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

17. Do you want a report sent to your attorney?

Yes No I have no attorney

18. Do you have any additional information that would be helpful in understanding your problem? _____

19. Please indicate last grade completed in school _____

20. To be sure paperwork is filled out correctly, please check if appropriate:

- | | |
|---|---|
| <input type="checkbox"/> On workman's compensation | <input type="checkbox"/> Receiving disability income |
| <input type="checkbox"/> Report should be sent to referring physician or family physician | <input type="checkbox"/> Legal proceeding pending |
| | <input type="checkbox"/> Report should be sent to another party |

Name: _____

Address: _____

21. Do you plan to return at your regular job in 6 months?

Yes No

PATIENT PAIN DRAWING

Name: _____ Date: _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching

^^^

Numbness

===

Pins & Needles

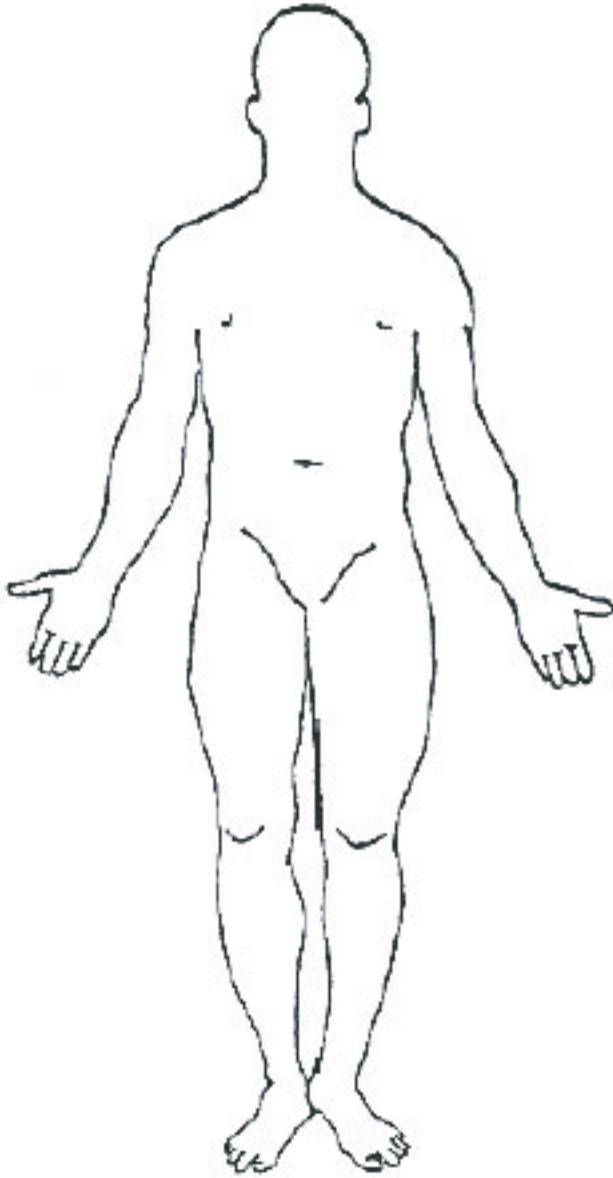
ooo

Burning

xxx

Stabbing

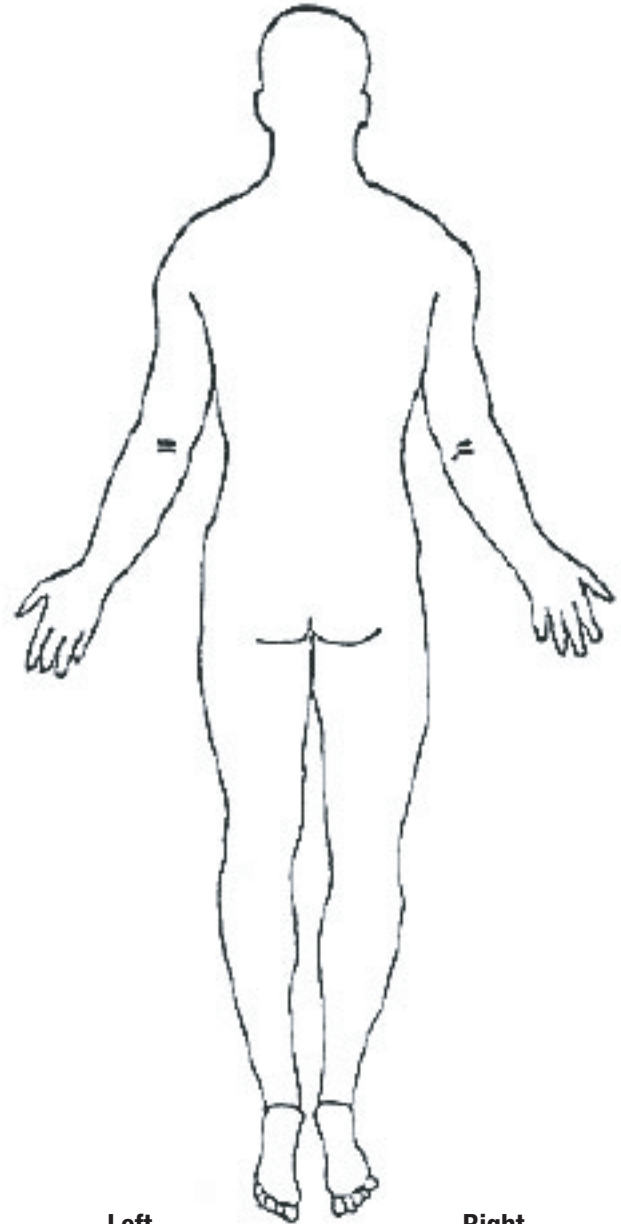
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Right

Front

Left



Left

Back

Right

How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line how bad your pain is now:

No pain _____ Worst possible pain