PATIENT HISTORY QUESTIONAIRE

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)
☐ Suddenly ☐ Pulling
☐ Gradually ☐ Injured at work
☐ Lifting ☐ Injured in auto accident
☐ Twisting ☐ Hit from behind
☐ Fall ☐ Injured during sports
☐ Bending ☐ No apparent cause

3. What activities make the pain worse?
☐ Exercise (during) ☐ Bending forward
☐ Exercise (after) ☐ Bending backward
☐ Sitting ☐ Coughing
☐ Standing ☐ Sneezing
☐ Walking

4. What reduces the pain?
☐ Lying down ☐ Pain pills
☐ Sitting ☐ Injections for pain
☐ Standing ☐ Muscle relaxant pills
☐ Walking ☐ Asprin or anti-inflammatory pills
☐ Manipulation ☐ Nothing
☐ Exercises in physical therapy ☐ 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	☐	☐	_____
CT (computed tomography) scan	☐	☐	_____
Myelogram (x-ray with dye injection	☐	☐	_____
Electromyogram (EMG)	☐	☐	_____
Discogram	☐	☐	_____
MRI (magnetic resonance imaging)	☐	☐	_____
Arthrogram or sonogram	☐	☐	_____
Injections	☐	☐	_____

7. Have you been hospitalizied 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?
☐ Stomach problems ☐ Cancer
☐ Diabetes ☐ Heart
☐ Arthritis ☐ Epilepsy
☐ Gout ☐ Weight loss
☐ Sexal difficulties ☐ Other (please explain)
☐ 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:
☐ On workman's compensation ☐ Receiving disability income
☐ Legal proceeding pending
☐ Report should be sent to referring physician or family physician ☐ Report should be sent to another party
Name: _____
Address: _____

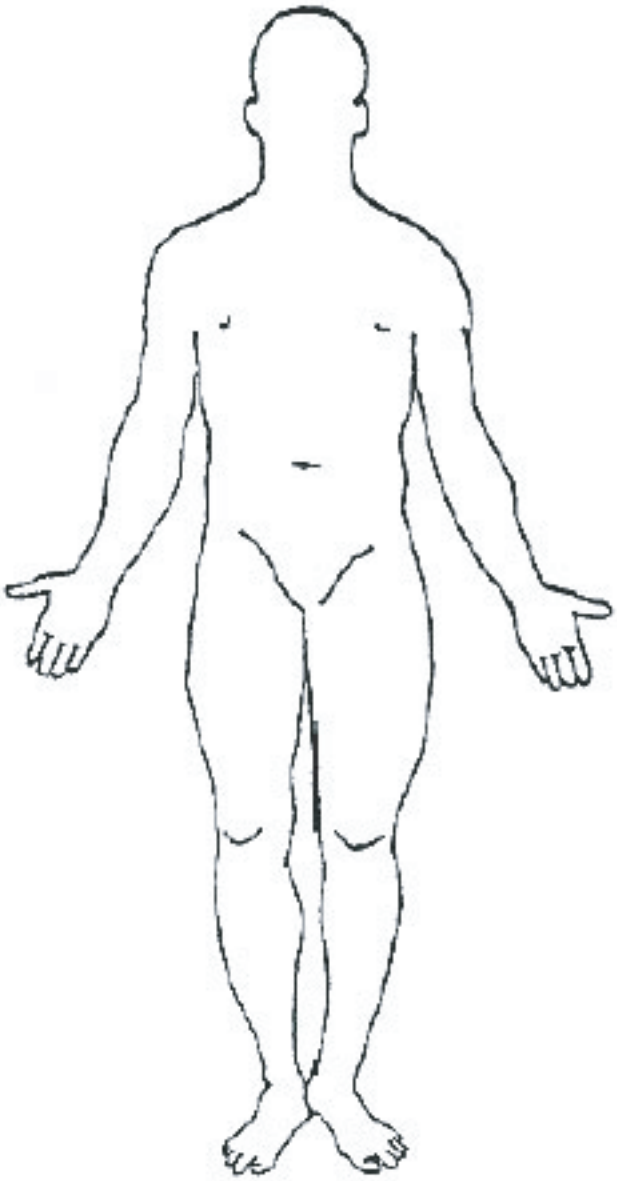
21. Do you plan to return at your regular job in 6 months?
☐ Yes ☐ No

PATIENT PAIN DRAWING

Name: _____ Date: _____

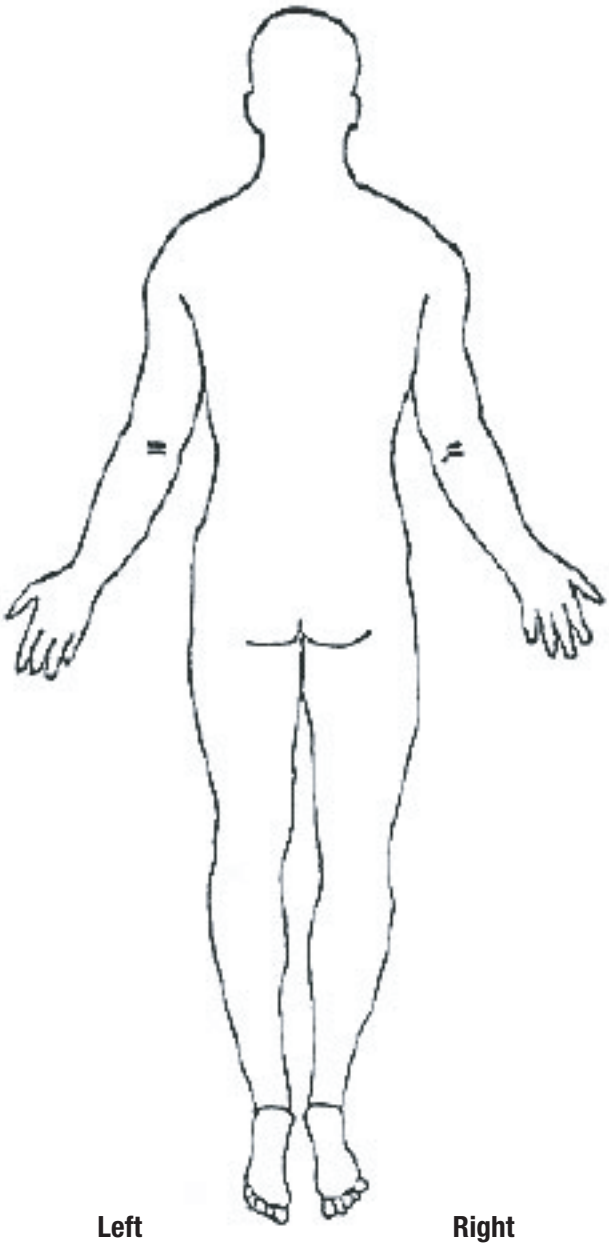
Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^	= = =	0 0 0	x x x	/ / /



Right Left

Front



Left Right

Back

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