PAIN HISTORY QUESTIONNAIRE

DATE: _____

NAME: _____

ADDRESS: _____

CITY / STATE / ZIP _____

CONTACT PHONE: _____

E-MAIL ADDRESS: _____

BIRTHDATE / AGE: _____

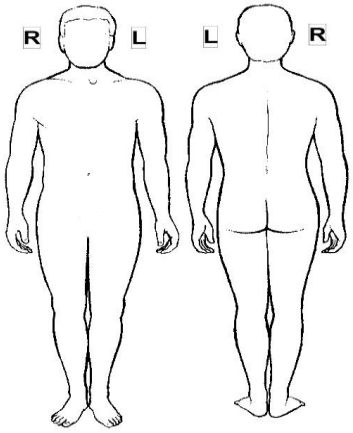
REFERRING DOCTOR: _____

EMERGENCY CONTACT _____

PLEASE HAVE OUR OFFICE COPY YOUR INSURANCE CARDS.

WHEN DID YOUR PAIN FIRST BEGIN? Month_____ Year_____

USING THE FIGURES BELOW, SHADE IN THE AREAS WHERE YOU HAVE PAIN



USING THE FOLLOWING PAIN SCALE (0 = NO PAIN, 10 = VERY SEVERE PAIN)

CIRCLE THE NUMBER THAT INDICATES YOUR PAIN

AT ITS BEST

0 1 2 3 4 5 6 7 8 9 10

AT ITS WORST

0 1 2 3 4 5 6 7 8 9 10

ON THE AVERAGE

0 1 2 3 4 5 6 7 8 9 10

COURSE: (CHECK ALL THAT APPLY)

____ CHRONIC
____ CONTINUOUS
____ DECREASING
____ IMPROVING
____ INTERMITTENT
____ INCREASED
____ RESOLVED
____ UNCHANGED
____ WORSENING

QUALITY: (CHECK ALL OF THE WORDS THAT DESCRIBE YOUR PAIN)

____ ACHING
____ BURNING
____ DULL
____MUSCLE CRAMPING
____MUSCLE SPASM
____MUSCLE WEAKNESS
____NUMBNESS
____SHARP
____SHOOTING
____STABBING
____THROBBING
____TINGLING

DURATION: (HOW LONG HAVE YOU HAD THE PAIN?)

____ DAYS
____ WEEKS
____ MONTHS
____ YEARS

ONSET/TIMING: (CHECK ALL THAT APPLY)

____ ACCIDENT RELATED
____ ACUTE ONSET
____ ILLNESS RELATED
____ INJURY RELATED
____ SURGERY RELATED
____ UNKNOWN CAUSE
____ WORK RELATED

CONTEXT/WHEN: (CHECK ALL THAT APPLY)

____ ACTIVITY
____ BENDING
____ CERTAIN POSITIONS
____ CHANGING POSITION
____ DRIVING
____ EXERTION
____ LIFTING
____ LYING DOWN
____ LYING ON THAT SIDE
____ MOTION
____ STANDING
____ SITTING
____ STRAINING
____ WALKING

IMPROVED BY: (CHECK ALL THAT APPLY)

___ ACTIVITY
___ ACUPUNCTURE
___ANALGESICS
___CHIROPRACTIC
___ EPIDURAL INJECTIONS
___EXERCISE
___FACET JOINT BLOCKS
___HEAT
___ICE
___MASSAGE
___MEDICATION
___NERVE BLOCKS OR INJECTIONS
___NOTHING
___ORAL STEROID MEDICATION
___PHYSICAL THERAPY
___REST
___TENS UNIT

HAVE YOU HAD ANY OF THE FOLLOWING TESTS DONE?

___X-Ray
___MRI
___CT-SCAN
___DISCOGRAM
___MYELOGRAM
___NERVE CONDUTION STUDIES
___EMG

WHAT OTHER PAIN PROBLEMS HAVE YOU HAD IN THE PAST?

___BACK PAIN
___FACIAL PAIN
___FIBROMYALGIA
___MIGRAINE HEADACHES
___ABDOMINAL OR PELVIC PAIN
___TMJ

HAVE YOU

___ HAD RECENT FALLS
___ HAD RECENT INFECTIONS
___ BEEN RECENTLY DIAGNOSED WITH CANCER
___ BEEN TAKING Cortisone, Prednisone or Steroids
___ HAD ANY PROBLEMS WITH YOUR BOWEL OR BLADDER

ARE YOU NOW TAKING COUMADIN OR OTHER "BLOOD THINNNERS"

___YES
___NO

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?

___Asthma/ Bronchitis
___Recent cold, flu, fever or infectious disease
___Heart problems
___Chest pain
___High blood pressure
___Hepatitis
___Diabetes
___Ulcers
___Gastritis
___Kidney disease
___Hiatal hernia or GERD
___Thyroid disease
___Seizures
___Stroke

SURGERY

HAVE YOU HAD SURGERY?

	Surgery	When	Where
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

MEDICATIONS

LIST ANY MEDICATIONS THAT YOU TAKE DAILY BELOW.

	Medication	Strength/Dose	Number of Pills per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES

ARE YOU SENSITIVE OR ALLERGIC (IE: RASH, SWELLING, ITCHY, TROUBLE BREATHING) TO ANY OF THE FOLLOWING:

___Penicillin
___Sulfa
___Codeine
___Aspirin
___Motrin, Advil or Ibuprofen
___Novocain
___Sleeping Pills
___Other _____

TOBACCO

DO YOU SMOKE?

___ NEVER A SMOKER

___ FORMER SMOKER

___ CURRENT EVERY DAY SMOKER

___ CURRENT SOME DAY SMOKER

IF YOU HAVE YOU EVER SMOKED?

FOR HOW MANY YEARS___ DATE QUIT_____

ALCOHOL

DO YOU DRINK ALCOHOL?

___ NONE

___ OCCASIONALLY (1 OR 2 DRINKS PER WEEK OR LESS)

___ MODERATE (1 OR 2 DRINKS PER DAY)

___ HEAVY (3 OR MORE DRINKS PER DAY)

SOCIAL HISTORY

ARE YOU

___Employed
___Retired
___Disabled

ARE YOU

___MARRIED
___SINGLE
___ DIVORCED
___ WIDOWED
___ DOMESTIC PARTNER
___ OTHER _____

DO YOU LIVE WITH

___ FAMILY
___ SPOUSE
___ ALONE
___ OTHER _____

DO YOU USE ANY RECREATIONAL DRUGS

___Yes ___No

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE (DRUGS OR ALCOHOL)

___Yes ___No

EXERCISE LEVEL

___ NONE

___ OCCASIONAL

___ MODERATE

___ HEAVY

WHAT DO YOU DO FOR EXERCISE?

_____A

PHYSICAL EXAM: (TO BE COMPLETED BY THE PHYSICIAN)

Physical Exam

HT _____ WT _____ BP ___ /___ P ____

APPEARANCE / GAIT

HEENT

NECK

LUNGS

HEART

ABDOMEN (OBESE/SCAPHOID) (SCARS)

PULSES RADIAL LEFT ____ RIGHT ____

EXTREMITIES EDEMA LEFT ____ RIGHT ____

BACK

- **AREA OF PAIN**
- **PARASPINAL MUSCLES**
- **FLEXION**
- **SENSORY**
- **STRENGTH**
- **SLR**
- **PATRICKS/FABER**
- **DTRS**