

# PATIENT HISTORY QUESTIONNAIRE



Date: \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

1. When did your present pain start: \_\_\_\_\_  
 \_\_\_\_\_

2. How did pain start? (check boxes)

Suddenly	Pulling
Gradually	At work
Lifting	Auto accident
Fall	Sports injury
Bending	Unknown

3. What reduces the pain?

Lying down	Pain pills: _____
Sitting	_____
Standing	Injections
Walking	Nothing
Manipulation	Other: _____
Exercises in P.T.	_____

4. What makes the pain worse?

Sitting	Bending forward
Standing	Bending backward
Walking	Coughing
Exercise	Sneezing
During	Other: _____
After	_____

5. Have you had any of these tests:

<u>Date</u>	<u>Where</u>
X-rays _____	_____
CT Scan _____	_____
Myelogram _____	_____
EMG _____	_____
Discogram _____	_____
MRI _____	_____
Arthrogram _____	_____

6. Have you had surgery for this problem?

Date \_\_\_\_\_

Type \_\_\_\_\_

By Dr. \_\_\_\_\_

7. List previous hospitalizations and / or medical problems:  
Dates  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. List medications you are currently on.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Do you have allergies? Please list.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Do you smoke?    No    Yes  
 How much? \_\_\_\_\_

11. Do you drink alcoholic beverages?    No    Yes  
 How much? \_\_\_\_\_

12. Please indicate last grade completed in school. \_\_\_\_\_  
 \_\_\_\_\_

13. Check any of the following boxes that apply.

Have filed worker's comp. claim  
 Report should be sent to Dr. \_\_\_\_\_

Legal proceeding pending with Atty. \_\_\_\_\_  
 \_\_\_\_\_

14. Additional information:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE COMPLETE BOTH PAGES OF THIS FORM. THANK YOU.**

# PAIN DIAGRAM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

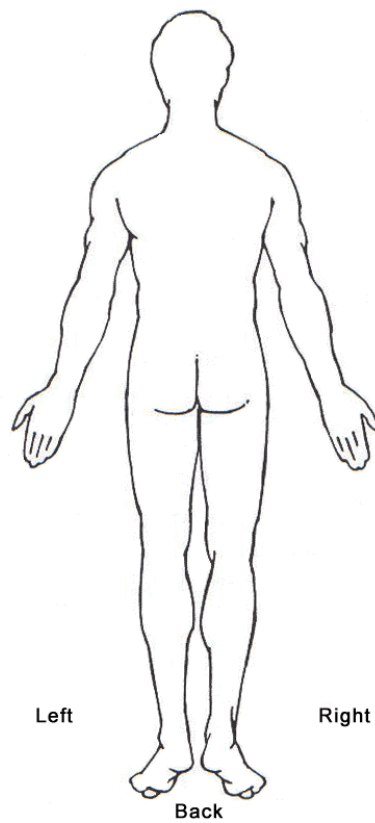
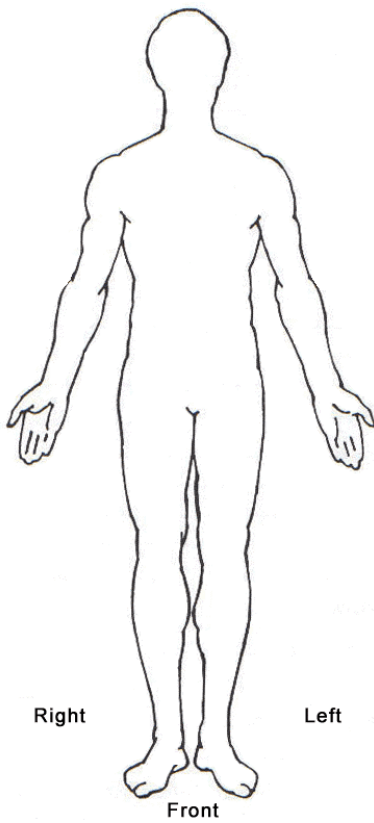
ACHEY PAIN  
/ / /

STABBING PAIN  
▽ ▽ ▽

BURNING  
= = =

NUMBNESS  
x x x

TINGLING  
o o o



On a scale from 0 to 10, describe your pain now. \_\_\_\_\_

0  
No Pain

10  
Worst Possible Pain

\_\_\_\_\_