PATIENT HISTORY QUESTIONNAIRE

NAME:_____**AGE:**_____**OCCUPATION:** _____**DATE:**_____

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

_____

2. How did the pain start? (Circle all that applies)

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? (Circle all that applies)

Exercise (During)	Bending Forward
Exercise (After)	Bending Backward
Sitting	Coughing
Standing	Sneezing
Walking	

4. What reduces the pain? (Circle all that applies)

Lying Down	Pain Pills
Sitting	Injections for pain
Standing	Muscle relaxant pills
Walking	Aspirin or anti-inflammatory pills
Manipulation	Nothing
Exercises in Physical Therapy	Other_____

5. How long have you had this pain?

_____years_____months_____weeks

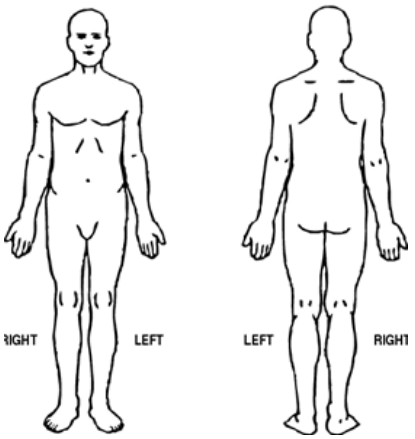
6. Have you been hospitalized for your pain problem?

☐ **YES** ☐ **NO** **# of times**_____**Dates**_____

7. Have you had surgery for this problem?

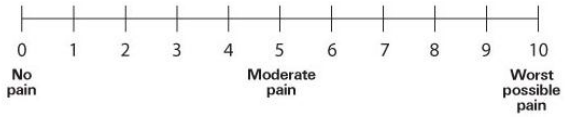
☐ **YES** ☐ **NO** **# of times**_____ **Dates**_____

Numbness	===
Dull Ache	000
Burning	xxx
Sharp, stabbing	///
Pins, needles	+++
Other _____	...

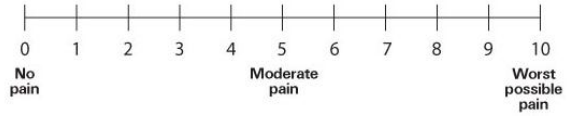


8. Average Intensity Pain

Last 24 Hours:



Past Week:



9. Have you had any of these diagnostic tests? (Circle all that applies)

Diagnostic X-rays	CT scan
Myelogram (X-ray with dye injection)	MRI
Electromyogram (EMG)	Discogram
Arthrogram or Sonogram	Injections

10. Have you been hospitalized for other medical problems?

☐ **YES** ☐ **NO** **Number of times**_____

Describe:

_____

11. What medications are you currently taking?

_____

_____

12. Do you have any of the following conditions? (Circle all that applies)

Stomach problems	Cancer
Diabetes	Heart
Arthritis	Epilepsy
Gout	Bowel or Bladder Problems
Sexual difficulties	Weight Loss
Other_____	

13. Do you have allergies?

☐ **YES** ☐ **NO** **Please List:**

_____

14. Do you smoke?

☐ **YES** ☐ **NO** **How much?** _____

Do you drink alcoholic beverages?

☐ **YES** ☐ **NO** **How much?** _____

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

_____

_____