RECURRENT PATIENT HISTORY QUESTIONNAIRE

NAME:____AGE:________OCCUPATION:__________________DATE:___________

1. How long has it been since you have attended this facility for this recurrent injury?

____

2. What activities make the pain worse? (Circle all that applies)

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

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

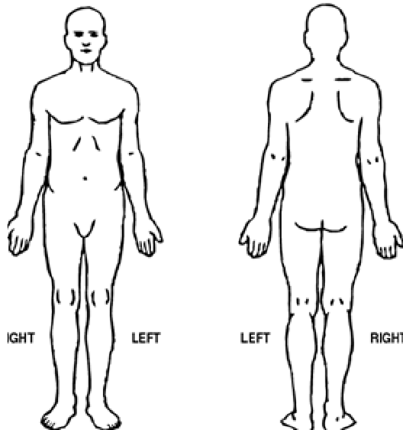
Lying Down	Pain Pills
Sitting	Injections for pain
Standing	Muscle relaxant pills
Walking	Aspirin or anti-inflammatory pills
Manipulation	Nothing
Exercises in Physical Therapy	Other_______________

4. Are you experiencing the same area and type of pain as we have seen you for previously?

☐ YES ☐ NO

5. Where is your pain now?

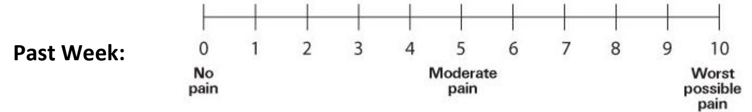
Numbness	===
Dull Ache	000
Burning	xxx
Sharp, stabbing	///
Pins, needles	+++
Other _______________	· · ·



6. Average Pain Intensity

Last 24 Hours:

Past Week:



7. Have you had any of these diagnostic tests for this injury since last attending this facility? (Circle all that applies)

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

8. Have you recently had surgery for this problem?

☐ YES ☐ NO # of times_________Dates___________________

9. Has anything changed in your medical history since attending this facility?

☐ YES ☐ NO

If yes, please describe:

____

____

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

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