Patient Questionnaire

Today's Date: _____/_____/_____

Your Information:

Last Name:_____ First: _____ Middle: _____

Date of Birth:_____/_____/_____ Age:_____ SS#:_____

Street:_____City:_____ State:_____ Zip Code:____

Home Phone: (____)_____ Work Phone: (_____)_____

Emergency Contact:

Name:_____ Relation: _____

Street:_____City:_____ State:_____ Zip Code:____

Home Phone:(____)_____ Work: (____)_____

Referring Physician:

Name:_____ Specialty:_____

Street:_____City:_____ State:_____ Zip Code:____

Phone: (____)_____ Fax: (____)_____

Primary Care Physician (PCP):

Name:_____

Street:_____City:_____ State:_____ Zip Code:____

Phone:(____)_____ Fax: (____)_____

Pharmacy:

Name:_____

Street:_____City:_____ State:_____ Zip Code:____

Phone:(____)_____

We can share information with your:

Spouse: _____ Significant Other: _____ Parent: _____ Children: _____ PCP: _____

Signature: _____

Marital status:_____ Number of children:_____

With whom do you live?_____

Do you practice any religion or have a personal faith system which helps you to cope with the pain?

_____

Please describe your pain complaint and location:

How and when did the pain start, and how has it changed since that time?

Please indicate on the following what makes the pain better (+) or worse (-):

____Heat	____Cold	____Humidity
____Sitting	____Standing	____Lying Down
____Coughing	____Fatigue	____Walking
____ Noise	____Anxiety/Emotions	____Massage
____Alcohol	____Caffeine	____Body position
____Sneezing	____Stairs	____Bowel movements
____Driving	____Vibrations	____Housework

0	1	2	3	4	5	6	7	8	9	10
no pain		mild		discomforting		distressing		horrible		excruciating

Using this pain scale, please describe your pain:

- at it's worst? _____
- at it's least? _____
- right now? _____

Circle any of the following that you currently use:

cane	wheelchair	crutches	brace
scooter	walker	prosthesis	collar

Please circle any treatments you have undergone for your pain problem. Place a (+) next to those that were effective and a (-) next to those that were not:

Acupuncture	Hypnosis	TENS unit
Bed Rest	Massage Therapy	Traction
Biofeedback	Physical Therapy	Trigger Point Injections
Chiropractor	Psychotherapy	Ultrasound
Exercise	Relaxation Training	Other:

Have you had any previous pain procedures like epidurals or nerve blocks? YES NO
When and with whom?

_____

Please list ALL MEDICATIONS you CURRENTLY take, including non-prescription medications and herbal formulas:

Name of Drug	Dose	Frequency

Please list PAIN MEDICATIONS you have taken in the PAST:

Name of Drug	Dose	Frequency	Effectiveness

Are you allergic to any foods(including shellfish and eggs), medications (including local anesthetic), or latex?

Drug	Type of Reaction

Please check any past or present medical conditions that apply to you:

___ angina
___ heart attack
___ heart failure
___ palpitations
___ heart murmur
___ irregular heart beat
___ hypertension
___ asthma
___ fractures
___kidney disease
___hepatitis
___stomach ulcers
___GERD
___diabetes
___ seizures
___depression
___ stroke
___ headaches
___ cancer
___ lupus
___ fibromyalgia
___ arthritis
___bleeding problems
___ thyroid problems
___ high cholesterol
___ bladder problems
___ enlarged prostate

List ALL previous surgeries with dates:

Any problems with anesthesia? Y N _____
Any blood transfusions? Y N _____
Any family history of pain problems? Y N _____

What is your height? _____ current weight? _____

Do you smoke? _____ If yes, how many packs/ years? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you use recreational drugs? _____ If yes, what? _____

Are you currently employed?_____ Occupation:_____

If unemployed, for how long?_____ Is this due to a pain condition?_____

Do you receive disability benefits?_____

If so, what type?_____

Do you have a pending settlement about disability, workmen's compensation or a legal matter? _____Yes _____No

If yes, explain briefly:_____

_____

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Please mark the area(s) of the body where your pain is on the figures below: