Patient Questionnaire

Today's Date:		in the second			
Your Information:					
Last Name:		Fi	rst:	Midd	dle:
Date of Birth:	_//_	Age:	SS#:		
Street:		_City:	S	tate:	Zip Code:
Home Phone: (
Emergency Cont				2.	
Name:			Relation:		
Street:	100 EXTENSION OF THE EX	_City:	S	tate:	Zip Code:
Home Phone:()	1	Work:	()	
Referring Physicic	an:				
Name:			Specialty:_		
Street:			S	tate:	Zip Code:
Phone: ()	e e e e e e e e e e e e e e e e e e e		Fax: (_)	
Primary Care Phy	sician (PCP)	<u>):</u>			
Name:		*			
Street:		_City:	S	tate:	Zip Code:
Phone:()			Fax: (_)	
<u>Pharmacy:</u>			2 4		
Name:					
Street:	¥ .	_City:	S	tate:	Zip Code:
Phone:()					
We can share info	ormation wi	h your:			
Spouse: Sign	nificant Oth	er: P	arent: C	:hildren:	_ PCP:
Signature:					a
Marital status: With whom do y Do you practice you to cope with	e any religio	on or have	Number of a personal	children: faith system	n which helps

A:\page1.doc(1998) Rev. 2001, 2004, 2006

Please describe your pain complaint and location:

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

Please indicate of the control of th	Sitting		es the pain better (+) or worse (-): HumidityLying DownWalkingMassageBody positionBowel movementsHousework				
0 1	2 3	4 5	6	7	8	9	10
no pain m	nild disco	mforting	distressing		horrible		excruciati
 at it's least? right now? Circle any of the cane scooter	- 	t you curren	tly use: crutches prosthesis		brace collar		
Please circle any next to those that	treatments you were effective	have undergand a (-) ne	one for your at to those th	pain at we	problem. ere not:	Pla	ce a (+)
Acupuncture Bed Rest Biofeedback Chiropractor Exercise		Hypnosis Massage Th Physical The Psychothero Relaxation T	rapy apy	Tra Trig Ultr	NS unit action gger Point rasound her:	Injed	ctions
Have you had an When and with w		procedures	like epidurals	or ne	erve block	cs?	YES NO

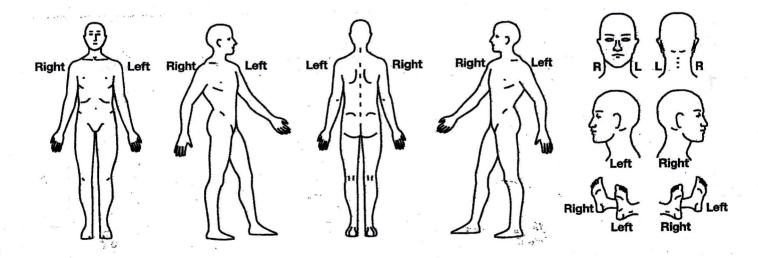
A:\page2.doc(1998) Rev. 2001, 2004

Please list <u>ALL MEDICATIONS</u> y medications and herbal form		ng non-prescription
Name of Drug	Dose	Frequency
Please list PAIN MEDICATIONS		
Name of Drug Do	ose Frequency	ElleCilvelless
		el , e
Are you allergic to any foods local anesthetic), or latex?	(including shellfish and eggs), medications (including
Drug	Type of Reaction	
Please check any past or p	resent medical conditions	that apply to you:
angina	kidney disease	cancer
heart attack	hepatitis stomach ulcers	lupus fibromyalgia
heart failure palpitations	GERD	arthritis
heart murmur	diabetes	bleeding problems
irregular heart beat	seizures	thyroid problems
hypertension	depression	high cholesterol bladder problem
asthma fractures	stroke headaches	enlarged prostate
	11044461165	o,ege a. p. e
List ALL previous surgeries v	vith dates:	
A	-!2 V N	
Any problems with anesthe Any blood transfusions? Y		
Any family history of pain p		

A:\page3.doc(1998) Rev. 2001, 2004

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?!	s this due to a pain condition?
Do you receive disability benefits?	¥
If so, what type?	
Do you have a pending settlement abo	out disability, workmen's compensation or a
legal matter?YesNo	
If yes, explain briefly:	
****************	**************************************

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



A:\page4.doc(1998) Rev. 2001, 2004