Patient Questionnaire

Please complete the form, print out and bring with you before your appointment.

Name: _____ **Date**: _____
Age: _____
Sex (Circle one): **M** **F**

Referring Physician: _____
Primary Care Physician: _____

Main Complaint: _____

When and **how** did your current problem start:

_____

_____

Did symptoms start (Circle one): **Suddenly** or **Gradually**? Getting worse? **Y** **N**

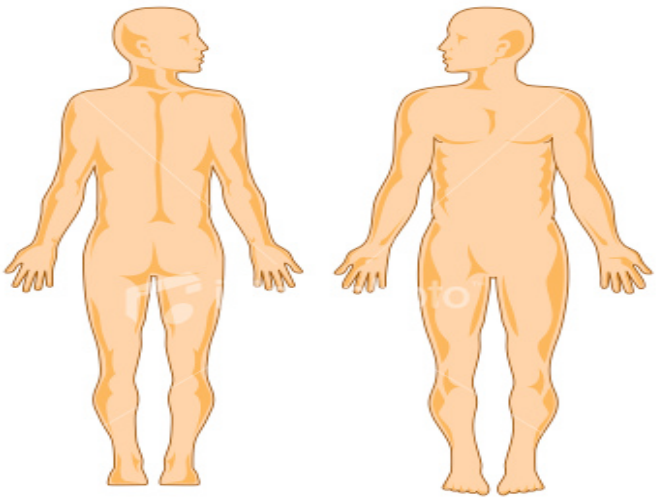
Have you ever had similar problems before? **Y** **N**

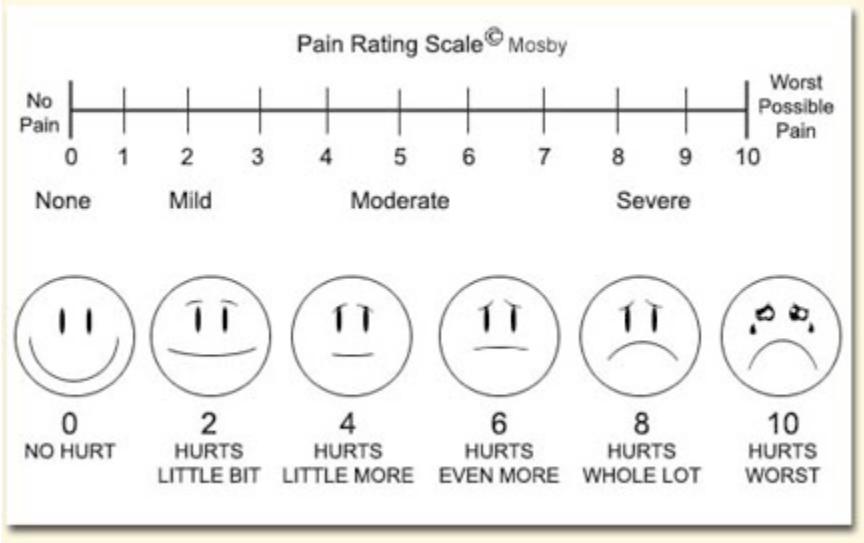
Is your pain (please circle one):
Constant **Intermittent, daily** **Intermittent, on most days** **Infrequent**

Describe your pain (circle as many as are applicable):

Burning	sharp electric-like	pins/needles shooting	stabbing
Numb	penetrating	aching/gnawing	dull
Throbbing	miserable	other _____	

Pain Location: Please mark location(s) of pain on diagrams below:





Using above scale, what was your **pain severity over the last month** (1-10): ____
Current pain level (1-10): ____

Relieving and Aggravating Factors: (Please check for each item):

	Decrease	No Change	Increase
Lying down	( )	( )	( )
Sitting	( )	( )	( )
Walking	( )	( )	( )
Bending forward	( )	( )	( )
Bending backward	( )	( )	( )
Coughing/Sneezing	( )	( )	( )
Bowel movements	( )	( )	( )
Medications	( )	( )	( )
Relaxation	( )	( )	( )

Medications for Pain:

1. Do you take any **opioids** (i.e.: Tylenol with codeine, Percocet, Vicodin, Dilaudid, Oxycontin, Methadone, Kadian, Fentanyl patch, etc.)? _____

   If so, what is the dose and frequency? _____

2. Do you take **anti-inflammatories**: (i.e., ibuprofen (Motrin, Advil), Naprosyn (Aleve), Aspirin, Lodine, Relafen, Ketorolac (Toradol), Vioxx, Celebrex)?

   If so, what is the does and frequency? _____

3. **Any other meds for pain** (muscle relaxants, neuropathic or antidepressant meds)?

_____

Please list all Current Medications:

_____

_____

_____

Past Medical History:

_____

_____

_____

Past Surgical History (Include dates if possible):

_____

_____

Family History: (Any spine problems, arthritis, major health problems or debilitating conditions in the family)?

_____

Occupation: _____

Social History (circle one): **married single partner children/grandchildren**
Are you alone? **Y N** Do you take care of yourself independently? **Y N**
(If needed, who helps you)?

_____

Do you have assistive devices? (cane, walker, braces): _____

Social Habits:
Do you**:**
Smoke: Y N How much? _____

Drink: Y N How much? _____

Take other non-prescription drugs? Y N How much? _____

Are you on disability? Y/ N **Since when? _____**

Previous treatments/management for your pain (Please describe):

_____

_____

_____

_____

What was most successful?

_____

What was least successful?

_____

Thank you for your time.