PAIN AND HISTORY QUESTIONNAIRE

Patient Name:____________________________________________  Date:______________________
Referring Doctor:____________________________________________
Other Doctor(s):____________________________________________

What is the reason for your visit?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Is your injury due to an accident? (check) ___work-related ___motor vehicle accident ___other ___N/A

Date of accident:___________________________________________

Describe:_____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Check where appropriate:

DEMO:               Age:____ Race:____  Gender: __M __F        ___right or ___left handed
                   Height:______ Weight:______ Neck Size:_____ BP:_____

SYMPTOMS:     Location:   ___low back  ___neck ___head
                   Leg: ___left ___right ___both   Arm: ___left ___right ___both

RADIATES TO:                      ___shoulder ___upper arm ___forearm ___fingers
                   ___buttock ___hip ___thigh ___leg ___ankle ___foot ___toes

CHARACTER:                        ___sharp___dull___stabbing___throbbing___aching___shooting___burning

INTENSITY:                           ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SYMPTOMS: ___weakness ___incontinence ___numbness ___tingling ___swelling
                   ___dizziness ___gait ___imbalance ___headache

FREQUENCY:                          ___intermittent ___only with activity ___constant

ONSET:                                    ___days ___weeks ___months ___years ___since accident

WHAT MAKES YOUR SYMPTOMS FEEL BETTER?   ___lying ___sitting ___walking ___standing ___heat
                   ___cold ___increased activity ___decreased activity ___propping with pillows ___no position of comfort

WHAT MAKES YOUR SYMPTOMS WORSE?   ___bending ___climbing stairs ___coughing ___driving
                   ___getting out of bed ___increased activity ___lying ___lifting ___sitting to standing ___sneezing
                   ___standing ___straining ___twisting ___walking
**WHAT TREATMENT HAVE YOU TRIED?**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Helped</th>
<th>Helped Temporarily</th>
<th>No Benefit</th>
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</thead>
<tbody>
<tr>
<td>Acupuncture</td>
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<td>Bed Rest</td>
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<td>Chiropractor</td>
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<td>Braces</td>
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<td>Epidural Steroid Injections</td>
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<td>Facet Blocks</td>
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<td>Trigger Point Injections</td>
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<td>Radiofrequency Ablation</td>
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<td>Physical Therapy</td>
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<td>Surgery</td>
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<tr>
<td>Wrist Splints</td>
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**WHAT MEDICATIONS HAVE YOU TRIED FOR THIS PROBLEM?**

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<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Schedule (times per day)</th>
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**LIST ALLERGIES** circle if NO ALLERGIES

<table>
<thead>
<tr>
<th>Medication/Allergen</th>
<th>Type of Reaction</th>
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**LIST DAILY MEDICATIONS**

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Schedule (times per day)</th>
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### PAST MEDICAL HISTORY

**ALLERGIES:**
- __hay fever__
- __seasonal__
- __other:______________________

**SKIN:**
- __eczema__
- __melanoma__
- __basal cell carcinoma__
- __squamous cell carcinoma__
- __neurofibromatosis__
- ___psoriasis

**EYES:**
- __cataracts__
- __glaucoma__
- ___macular degeneration__
- ___torn retina
- ___legally blind

**EARS:**
- ___deafness__
- ___inner ear problems__
- ___ringing in ear (tinnitus)__
- ___vertigo

**RESPIRATORY:**
- __asthma__
- ___lung cancer__
- ___chronic bronchitis__
- ___respiratory failure
- ___COPD(chronic obstructive pulmonary disease)__
- ___emphysema__
- ___pneumonia

**CARDIAC:**
- ___angina__
- ___irregular heartbeats__
- ___atrial fibrillation__
- ___cardiac arrest
- ___heart attack__
- ___hypertension__
- ___stroke

**GASTRO-INTESTINAL:**
- ___ulcers__
- ___reflux disease (GERD)__
- ___stomach cancer__
- ___diverticulitis
- ___colon cancer__
- ___Crohn’s disease__
- ___ulcerative colitis__
- ___cirrhosis
- ___hepatitis__
- ___liver cancer__
- ___pancreatitis__
- ___pancreatic cancer

**URINARY/RENAL:**
- ___kidney failure (on dialysis)__
- ___single kidney__
- ___stones__
- ___urinary tract infection__
- ___enlarged prostate__
- ___erectile dysfunction__
- ___sexually transmitted disease__
- ___infertility

**VASCULAR:**
- ___peripheral vascular disease__
- ___abdominal aortic aneurysm__
- ___DVT/blood clots__
- ___pulmonary embolus (blood thinner)

**MUSCULOSKELETAL:**
- ___arthritis__
- ___rheumatoid__
- ___osteoarthritis__
- ___fibromyalgia__
- ___gout
- ___scoliosis

**NEUROLOGICAL:**
- ___headache__
- ___migraine headache__
- ___brain tumors__
- ___cerebral aneurysm
- ___stroke__
- ___seizures__
- ___Parkinson’s disease__
- ___dementia

**HEMATOLOGIC:**
- ___anemia__
- ___leukemia__
- ___lymphoma__
- ___HIV/AIDS__
- ___bleeding disorder

**CANCER:**
- ___breast__
- ___cervical__
- ___colon__
- ___esophagus__
- ___lung__
- ___ovarian__
- ___prostate__
- ___skin__
- ___stomach__
- ___throat__
- ___uterine

**ENDOCRINE:**
- ___high or low thyroid__
- ___diabetes mellitus (diet controlled, meds or insulin)__
- ___pituitary disorder

**PSYCHIATRIC:**
- ___anxiety disorder__
- ___depression__
- ___bipolar disorder__
- ___substance abuse

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### PAST SURGICAL HISTORY

**GENERAL:**
- ___appendix__
- ___urinary bladder__
- ___gall bladder__
- ___facial surgery__
- ___hernia__
- ___bowel resection__
- ___colon polyp removal__
- ___hemorrhoidectomy

**ORTHOPEDIC:**
- ___shoulder__
- ___arm__
- ___wrist__
- ___hand__
- ___hip__
- ___femur__
- ___knee__
- ___ankle__
- ___foot__
- ___cervical__
- ___thoracic__
- ___lumbar

**NEUROSURGERY:**
- ___brain aneurysm__
- ___tumor__
- ___subdural hematoma__
- ___other:______________________

**VASCULAR:**
- ___carotid__
- ___femoral-popliteal bypass__
- ___abdominal aortic aneurysm__
- ___vain stripping

**ENT:**
- ___tonsillectomy__
- ___thyroid__
- ___ear__
- ___sinus

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**Patient Name:_________________________  Date:____________________**
HEART:  ___pacemaker ___bypass ___valve
COSMETIC:  ___tummy tuck ___facelift ___breast augmentation ___other: ________________
BREAST:  ___mastectomy ___lumpectomy ___biopsy
OTHER:  ___hysterectomy ___prostatectomy ___other: ________________

SOCIAL HISTORY

OCCUPATION: ___________________________________________________________________________
WORK STATUS: working:  ____full time ____part time ___on restrictions: ___________________________
not working:  ___from symptoms or ___not from symptoms
TIME OFF WORK SINCE ACCIDENT: Date: ____________________ Days ___ Weeks ___ Months ___

DISABILITY:  ___back problems ___heart ___mental health ___other: ________________
How long on disability? _____ Who placed you on disability? _______________________
MARITAL STATUS:  ___Single ___Married ___Divorced ___Widow(er)
NUMBER OF CHILDREN: ___________

HABITS:  Tobacco:  ____ No or ____ packs per day x ____ years
Alcohol:  ____ No or ____drinks per day  or ____ socially
Recreational drug use ___ no ___ yes  drug of choice: _____________________________
Drug use in present: _____ or past: _______ Rehab: _______________________
How long did you abuse drugs: ___________ How long sober: _______________

FAMILY MEDICAL HISTORY
_____ PREMATURE HEART DISEASE (death or MI before 60)
_____ CANCER AND TYPE (if known) _________________________________________________
_____ DIABETES
_____ STROKE

REVIEW OF SYMPTOMS

NEUROLOGICAL:  ____ tremors ___ dizzy spells ___ numbness ___ tingling ___ weakness
EYES:  ___ double vision ___ glaucoma ___ cataracts ___ blind spots ___ blurry vision
ENT:  ___ hearing problems ___ sore throat ___ sinus problems ___ mouth infections
_____ ringing in ears
CARDIOVASCULAR:  ____ chest pain ___ palpitations
PULMONARY:  ____ wheezing ___ cough ___ shortness of breath
GASTRO-INTESTINAL:  ____ abdominal pain ___ nausea ___ vomiting ___ indigestion ___ heartburn
GASTRO-URINARY:  ____ difficulty urinating ___ burning ___ frequency greater than 8x per day
PSYCHOLOGICAL:  ____ depressed ___ anxious
MUSCULOSKELETAL:  ____ bone pain ___ muscle pain ___ joint pain
ENDOCRINE:  ____ excessive thirst ___ too hot or cold ___ tired or sluggish
HEMATOLOGIC/LYMPH:  ____ swollen glands ___ blood clots ___ excessive bleeding ___ bruising
VASCULAR:  ____ history of blood clots ___ peripheral vascular disease ___ edema
SKIN:  ____ rashes