

Thank you in advance for taking the time to complete this detailed confidential questionnaire. Please bring it with you to your first appointment.

Name _____ Age _____ Right handed Left handed

Referring Physician _____

Primary Care Physician _____ City _____

City of Residence _____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU WERE INJURED ON THE JOB

Is this a work related injury or illness? Yes No

Is this an accidental injury? Yes No car accident fall other _____

Date of Injury _____ When did you first notice pain? _____

Are you currently working? Yes No Full duty Light duty

If yes, then how many hours each day? _____ What are your job responsibilities? _____

Is your supervisor sympathetic to your needs? Yes No

If you are not working, how long have you been out of work? _____

Have you tried to return to work? Yes No

When? _____ What circumstances caused you to stop? _____

Have you ever had a similar problem with pain? Yes No Please describe _____

Is there a Rehab, nurse, counselor, or Vocational specialist working with you? Yes No

If so, name and phone number _____

What event caused your pain or impairment? Disease Accident Surgery Unknown

Describe what happened (mechanism of injury) _____

Was the onset of your pain sudden or more gradual? _____

Did you go to the Emergency Room? Yes No When? _____ Where? _____

What tests did they perform? _____

What treatment did you receive? _____

Please list all other physicians who have treated you for this condition _____

<p>Check all diagnostics test that have been performed:</p> <p><input type="checkbox"/> X-ray <input type="checkbox"/> Bloodwork</p> <p><input type="checkbox"/> Cat Scan <input type="checkbox"/> EMG / Nerve Conduction Studies</p> <p><input type="checkbox"/> MRI <input type="checkbox"/> Myelogram / Discogram</p>	<p>Results:</p>
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Patient Name _____

PAIN DESCRIPTIVES

Describe your pain: Sharp Stabbing Shooting Burning Throbbing Pulsating
 Aching Tingling Numb Terrifying Agonizing

Does pain shoot or refer to another part of your body? Yes No Where? _____

Is the pain constant intermittent occasional _____ Minutes per day _____ Hours per day

Do you occasionally need to stop all activities because of pain? Yes No If yes, number of times: _____ daily _____ weekly

Do you experience any associated symptoms such as: (check)

- Headaches Dizziness Memory Problems Muscle spasm
- Nausea Vomiting Balance Disturbance Cough, short of breath
- Weakness Numbness Bowel Dysfunction Blood in urine/stool
- Fatigue Irritability Difficulty Walking Bladder dysfunction
- Depression Anxiety Weight Gain/Loss Hair loss
- Swelling Change in swallow/sight _____ lbs? Coldness Warmth

Please rate your pain: Visual Analog Scale 0 1 2 3 4 5 6 7 8 9 10
(no pain) (extreme pain)

Today _____ Average day _____ Good day _____ Bad day _____

What makes your pain better? (Please check all that apply.)

lying down walking sitting standing medication
 sleep heat massage exercise stretching
 traction TENS corset biofeedback compression

Other _____

What makes your pain worse? (Please check all that apply.)

standing sitting walking bending tension
 lack of sleep lying down lifting weather driving
 reaching over head sexual activity

Other _____

Do you have severe night time pain? Yes No

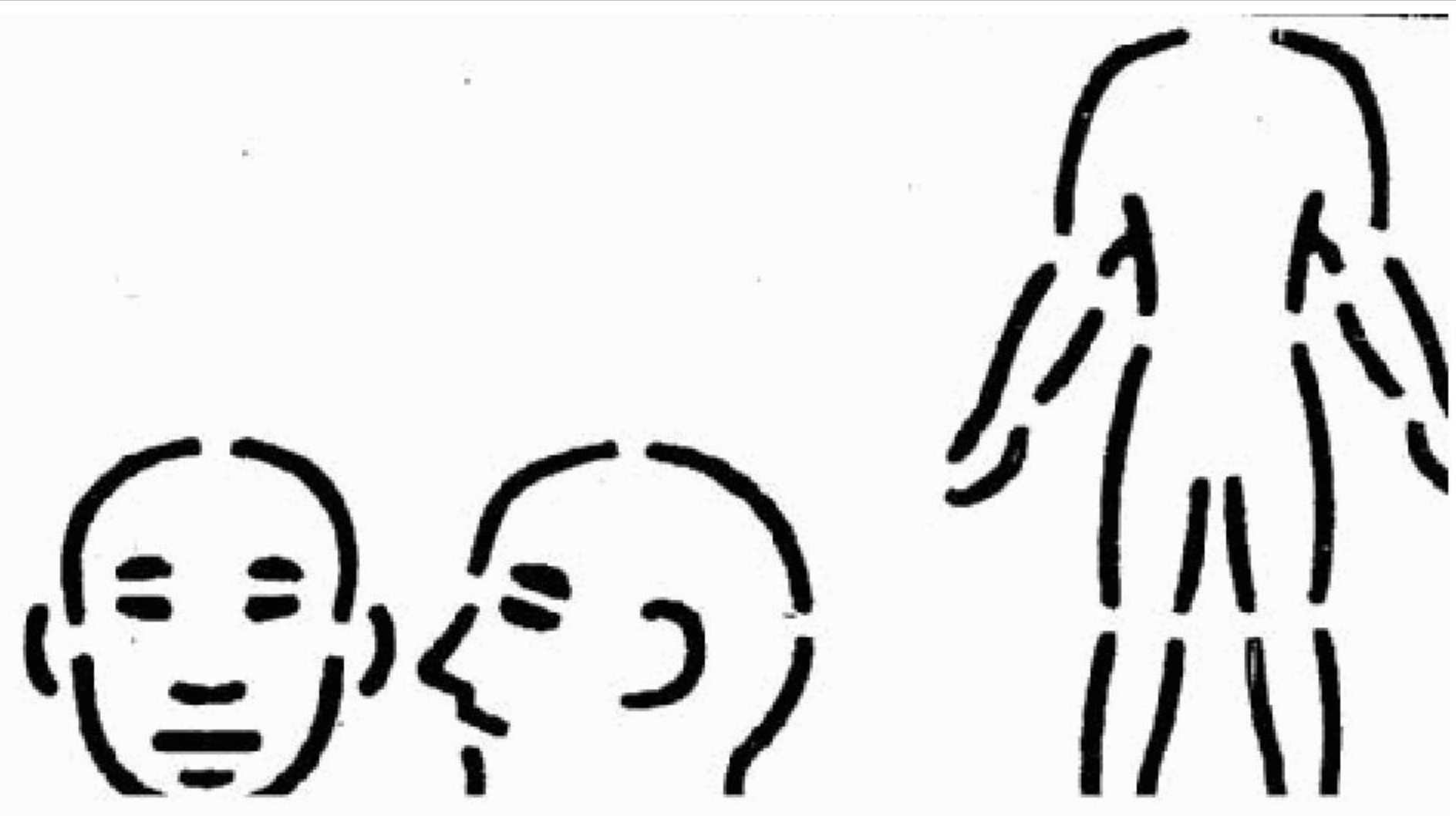
Do you wake up in the middle of the night because of pain? Yes No If yes, how many times? _____

Do you have difficulty falling asleep at night? Yes No

Do you wake up unusually early in the morning? Yes No

Pain Diagram: Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations. Please number each painful area in order the most troublesome, i.e. 1-10 on the diagram

- Key:** →→→ = shooting
 /// = stabbing
 XXXX = aching
 0000 = throbbing
 ●●●● = pins & needles
 **** = burning



Patient Name _____

Previous Treatment (check all that apply)

PHYSICAL THERAPY

- Ultrasound
- Hot packs
- Traction
- Electrical stimulation
- Soft tissue release
- Therapeutic exercise

TENS

Biofeedback

Chiropractic

Brace / splint / cervical collar

Back school education Yes No

Work hardening

Injections (trigger point, facet block, nerve block, epidural, sympathetic block)

Acupuncture

Implants / Pumps

Pain Clinic Yes No

Where? _____ When? _____

Temporary Relief

Lasting

- | | | | |
|------------------------------|-----------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you have seen or are currently seeing a Psychologist or Psychiatrist, please list their name _____

Do you like to exercise? Yes No

Do you have time to exercise? Yes No

Do you have access to a community fitness facility? Yes No

Past Medical History

Please circle all previous medical problems (heart, lung, kidney, intestinal, stomach, liver diseases, thyroid problem, diabetes, high blood pressure, cancer, stroke, seizure disorder, blood clots, osteoarthritis, osteoporosis)

Other _____

List any previous surgery _____

List All Current Medications

List all known medication allergies or intolerances _____

Check all medications that have been used for this condition

Anti-Inflammatory

Anti-Convulsants

Opiates

Other

- | | | | | | |
|------------------------------------|------------------------------------|---|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Mobic | <input type="checkbox"/> Neurontin | <input type="checkbox"/> Lortab | <input type="checkbox"/> Actiq | <input type="checkbox"/> Ultram | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Naprosyn | <input type="checkbox"/> Lamictal | <input type="checkbox"/> Darvocet | <input type="checkbox"/> Morphine | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Effexor |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Percocet | <input type="checkbox"/> Dilaudid | <input type="checkbox"/> Elavil | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Voltaren | <input type="checkbox"/> Tegretol | <input type="checkbox"/> OxyContin | <input type="checkbox"/> Mepergan | <input type="checkbox"/> Pamelor | <input type="checkbox"/> Xanax |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Other | <input type="checkbox"/> Tylenol #3 | <input type="checkbox"/> Kadian | <input type="checkbox"/> Clonidine | <input type="checkbox"/> Celexa |
| <input type="checkbox"/> Other | | <input type="checkbox"/> Fentanyl Patch | <input type="checkbox"/> Other | <input type="checkbox"/> Zanaflex | <input type="checkbox"/> Zoloft |
| | | | | <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Paxil |
| | | | | <input type="checkbox"/> Lyrica | <input type="checkbox"/> Flexeril |
| | | | | <input type="checkbox"/> Robaxin | |

Patient Name _____

SOCIAL HISTORY

Are you: Single Married Separated Divorced Widowed

Do you have children? Yes No If yes, how many children and their ages _____

Is your spouse healthy? Yes No Are your children healthy? Yes No

Is there a history of abuse? Physical Verbal Sexual What is your educational level? _____

Do you live in an apartment house townhouse? How many stories / levels? _____

Have you ever smoked? Yes No Age started _____ Age stopped _____ How many cigarettes per day? _____

Number of cups of coffee _____ tea _____ soda _____ per day.

Have you ever or do you currently drink alcohol? Yes No

Do you have or any family members drink excessively? Yes No If yes, who? _____

Have you ever or do you currently used recreational drugs? Yes No

Type and amount per day week month _____

Stresses

Relationships Family Friends Home Work

Job Satisfaction? Yes No Why? _____

How do you react to stress? _____

Previous functions: circle activities below you previously enjoyed / participated in, that you are now unable to do due to this condition.

Household Activities: dishes, laundry, vacuum, cooking, yard work other: _____

Exercise: outdoor walking, bicycle, swimming, treadmill, weights, jog other: _____

Hobby: read, t.v., puzzles, fishing, hunting, sewing, musical instrument, gardening other: _____

Personal: bathing, dressing, driving, sexual activity, make-up, brush teeth other: _____

Family History (Please check all that apply.)

- | | | | |
|--|---|--|---------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anemic |
| <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Kidney Disease | | |

Doctor to Complete

EXAM

Generally _____

Spine _____

Nero _____

Vascular _____

Gait _____

Extremity _____

Skin _____

DX / TX

GI/GU N/A – Cardio Pulmonary N/A