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Patient History Questionnaire

Date _____ Physician you are seeing: _____

NAME: _____ **Age:** _____ **Date of Birth:** _____

Referring Physician: _____ Phone Number: _____

PCP name: _____ Phone Number: _____

Height _____ Weight _____

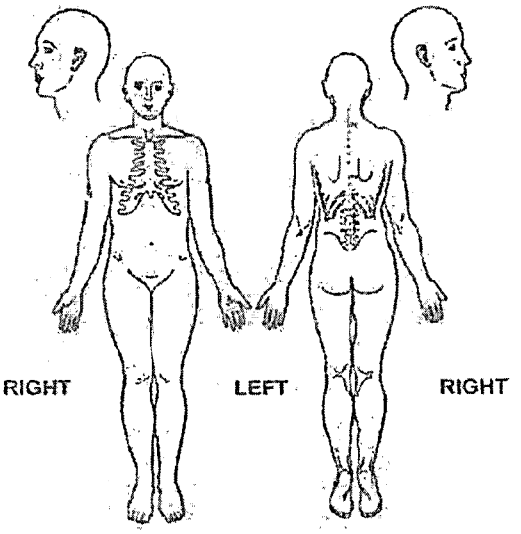
Briefly describe your main pain complaint: _____

_____

How did your pain originally begin? (check one)

- ☐ Accident at work Date: ____/____/____
- ☐ Following surgery Date: ____/____/____
- ☐ Pain just began Date: ____/____/____
- ☐ Other _____ Date: ____/____/____
- ☐ Auto accident Date: ____/____/____
- ☐ Following an illness Date: ____/____/____

Below, please shade in the area where you have pain, put an "X" over the area that hurts the most.



Check the box(s) that BEST describes *your current pain:*

- ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Cramping ☐ Stinging ☐ Squeezing
- ☐ Hot ☐ Burning ☐ Piercing ☐ Tingling ☐ Tender ☐ Aching ☐ Splitting
- ☐ Cold ☐ Dull ☐ Numb ☐ Gnawing ☐ Other: _____

Rate your pain by placing an "X" on the line to describe your AVERAGE pain the past month:

(NO PAIN) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine)

How often do you have your pain?

☐ Constant ☐ Most of the time ☐ Occasionally ☐ Rarely

In general, when is your pain worse?

☐ No specific time Morning ☐ Afternoon ☐ Evening ☐ Bedtime

Which of the following *makes your pain worse*? (Check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Bending/Twisting ☐ Lifting ☐ Lying ☐ Exercise
☐ Lying ☐ Bright Lights ☐ Heat ☐ Stress ☐ Cold ☐ Inactivity ☐ Alcohol
☐ Meals ☐ Menstruation ☐ Poor Sleep ☐ Weather Changes ☐ Loud Noise
☐ Medication: _____ ☐ Other: _____

Which of the following *makes your pain better*? (Check all that apply)

☐ Cold ☐ Exercise ☐ Activity ☐ Warm Shower ☐ Relaxation ☐ Prayer
☐ Heat ☐ Distraction ☐ Medication: _____ ☐ Other: _____

Are there any other symptoms *associated with your pain*?

☐ Numbness ☐ Weakness ☐ Tenderness ☐ Vomiting
☐ Redness ☐ Bowel Incontinence ☐ Urinary Incontinence ☐ Fatigue
☐ Swelling ☐ Blurred Vision ☐ Night time movements ☐ Anger
☐ Sexual Dysfunction ☐ Nausea ☐ Sleep Apnea
☐ Other: _____

Has your pain affected your mood? ☐ No ☐ Yes: (describe) _____

Has your pain affected your sleep? ☐ Never ☐ Rarely ☐ Occassionally

TREATMENTS:

Please check any of the following treatments that you have tried to treat your pain: ☐ **NONE**

☐ Acupuncture ☐ Chiropractor ☐ Physical Therapy ☐ Hypnosis
☐ Biofeedback ☐ Traction ☐ TENS ☐ Psychotherapy
☐ Bed Rest ☐ Exercise ☐ Pain Clinic ☐ Injection Therapy
☐ Other: _____

MEDICAL HISTORY

Do you have any of the following? (please check all that apply) ☐ **NO PROBLEMS**

☐ High Blood Pressure ☐ Heart Attack ☐ Asthma ☐ Stomach Ulcer
☐ Kidney Disease ☐ Seizure ☐ Depression ☐ Arthritis
☐ Diabetes ☐ Stroke ☐ Hepatitis ☐ Cancer
☐ Thyroid Disease ☐ Liver Disease ☐ Lung Disease ☐ Fibromyalgia
☐ Pacemaker ☐ HIV ☐ A-Fib ☐ Peripheral Neuropathy
☐ GERD ☐ Bowel Disease ☐ Migraines ☐ On a Blood Thinner
☐ Low Blood Sugar ☐ Dialysis ☐ Glaucoma
☐ OTHER: _____

SURGICAL HISTORY

Have you ever had any type of surgery? ☐ No ☐ Yes If yes, please list below:

Procedure: _____ Date: _____ Surgeon: _____
Procedure: _____ Date: _____ Surgeon: _____
Procedure: _____ Date: _____ Surgeon: _____

PAST MENTAL HEALTH HISTORY:

Have you ever had mental health treatment? ☐ No ☐ Yes: _____ (Approximate date)

Are you in current mental health treatment? (Psychiatrist, Psychologist, Counselor)
☐ No ☐ Yes: _____ (Name of Provider

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes: _____ (Approximate date)

If Yes: General reason for hospitalization: _____

ALLERGIES:

Are you allergic to any medications or foods? ☐ NO ☐ YES: List below

YES	NO	MEDICATION	REACTION	MILD	MODERATE	SEVERE	UNKNOWN
		PENICILLIN		☐	☐	☐	☐
		SULFA		☐	☐	☐	☐
		IV DYE		☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
		Non-Medication / Food Allergies					
		LATEX		☐	☐	☐	☐
		SHELLFISH (Lobster, shrimp, clams, etc)		☐	☐	☐	☐
		STRAWBERRIES		☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Please list ALL medications that you are CURRENTLY taking. (Include meds for pain, heart, diabetes, blood pressure, blood thinners, as well as over the counter medications and herbal products, etc)

Date Started	Medication	Dosage	Frequency	Ordering Physician

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed: How long? _____

Are you pregnant or planning on becoming pregnant? ☐ N/A ☐ No ☐ Yes: Due Date: _____

If you have children:

Name	Age	Grade	Any areas of concern about this child

EMPLOYMENT:

Current Occupation: _____ ☐ N/A

Present employment status: ☐ Full-time ☐ Part-time ☐ Student ☐ Homemaker ☐ Retired
☐ Workers Compensation ☐ Unemployed ☐ Leave of Absence ☐ Disability

If not working, when was your last day of work? _____ Date you returned to work after injury: _____

Would you return to work if you had less pain? ☐ Yes ☐ No

Have you tried to return to work? ☐ Yes ☐ No

Is your present or previous job remaining open for you? ☐ Yes ☐ No

Do you have an application pending for compensation or disability? ☐ Yes ☐ No

Do you have a pending lawsuit because of your pain or injury? ☐ No ☐ Yes: _____
(Name of your Attorney)

LIFESTYLE HABITS:

How much caffeine (coffee, tea, pop/soda) do you consume in a day? _____ cups

SMOKING STATUS: ☐ Current every day smoker (Packs per day _____) Year started _____
☐ Current some day smoker (# of cigarettes _____) ☐ Unknown if ever smoked
☐ Former smoker: Year Start _____ Quit _____ ☐ Never smoked

Do you drink alcohol? (Wine, beer, liquor) Never Quit: When? _____
☐ None ☐ Rarely (1 per month) ☐ Occasionally (less than 1 per week)
☐ Daily ☐ Regularly (2-3 per week) ☐ Yearly

Have you ever been recommended to a drug or alcohol rehab program?
☐ Never ☐ Yes (Indicate when) _____

Have you ever participated in a drug or alcohol rehab program? ☐ Never ☐ Yes (Indicate when) _____

Have you ever used recreational (street) drugs? ☐ Never ☐ Yes: List Below:

YES	NO	NAME OF STREET DRUG	WHEN	HOW TAKEN
		Cocaine		
		Heroin		
		Marijuana		
		LSD		
		OTHER		

Does your immediate *family (parents, brother/ sister)* have a history of:

Back Disorder	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Thyroid Disease	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes
Heart attack under age 50	☐ No	☐ Yes	Migraines	☐ No	☐ Yes
Cancer:	☐ No	☐ Yes: (type) _____			
Pain Problem	☐ No	☐ Yes: (type) _____			

☐ Adopted ☐ Unknown

REVIEW OF SYSTEMS: Please check all CURRENT symptoms:

CONSTITUTIONAL ☐ NO PROBLEMS

☐ Lack of energy ☐ Weight Loss: Amount: _____ Was this intentional? ☐ Yes ☐ No
☐ Trouble Sleeping ☐ Weight Gain: Amount: _____ Was this intentional? ☐ Yes ☐ No
☐ Poor appetite ☐ Fevers
☐ Chills ☐ Night Sweats

RESPIRATORY ☐ NO PROBLEMS
☐ Shortness of Breath ☐ Chronic Cough ☐ Wheezing
☐ Oxygen: @_____ Liters (circle) Day / Night / Continuous
☐ Other: _____

CARDIOVASCULAR ☐ NO PROBLEMS
☐ Chest pain ☐ Leg pain/poor circulation ☐ Swelling in legs & feet
☐ Palpitations ☐ Irregular Heart beats ☐ Cold hands & feet
☐ Blue / Red color changes in hands and feet ☐ Narrowing of arteries of the neck
☐ Other: _____

GASTROINTESTINAL ☐ NO PROBLEMS
☐ Difficulty chewing or swallowing ☐ Poor Appetite ☐ Diarrhea
☐ Constipation ☐ Blood in stool ☐ Dark or tarry stools
☐ Nausea / Vomiting ☐ Abdominal Cramps / Bloating ☐ Yellow skin
☐ Weight Loss ☐ Incontinence of Stool ☐ Change in stools
☐ Abdominal pain ☐ Other: _____

HEMATOLOGIC ☐ NO PROBLEMS
☐ Painful veins or arteries ☐ Trouble with blood clotting ☐ Easy Bruising

ENDOCRINE ☐ NO PROBLEMS
☐ Weight gain ☐ Always cold ☐ Always hot ☐ Other: _____

MUSCULOSKELETAL ☐ NO PROBLEMS
☐ Muscle Pain ☐ Joint Pain ☐ Muscle Loss ☐ Weakness ☐ Stiffness
☐ Cramps ☐ Bone pain ☐ Other: _____

NEUROLOGICAL ☐ NO PROBLEMS
☐ Headache ☐ Fainting ☐ Difficulty finding words when thinking
☐ Difficulty walking ☐ Poor Memory ☐ Change in your thinking
☐ Falls ☐ Poor Concentration ☐ Numbness or tingling of face / arms / legs
☐ Other: _____

PSYCHIATRIC ☐ NO PROBLEMS
☐ Frequent sadness/feeling unhappy ☐ Panic ☐ Excessive worry
☐ Unusually high energy/excitability ☐ Ongoing problems in relationships with others
☐ Anger ☐ Other: _____

GENITOURINARY ☐ NO PROBLEMS
☐ Urinary Frequency ☐ Incontinence of Urine ☐ Pain when urinating
☐ Pain during sex ☐ Blood in urine ☐ Other: _____

GYNECOLOGICAL ☐ NO PROBLEMS
☐ Period Irregularity ☐ Hot Flashes ☐ Heavy Periods ☐ PMS symptoms
☐ Currently Lactating ☐ Absence of periods ☐ Painful Periods ☐ Other: _____

Was this form completed by someone other than the patient? ☐ No ☐ Yes: whom? _____
Relationship: _____

Patient/Guardian Signature: _____ Date: _____