PATIENT HISTORY QUESTIONNAIRE

Name:_____ Date of Birth (M/D/Y):_____

Address:_____ Sex:_____ Age:_____

Telephone#:_____

Who referred you to this office?_____

Dominant Hand: (Circle) R L Ambidextrous

PAIN HISTORY

1. Where is your pain:_____

   _____

2. When did your pain begin (month/year):_____

3. What brought on your pain?_____

   _____

4. Is your pain the result of:

_____ Direct Blow	_____ Gradual Onset	_____ Pushing
_____ Fall	_____ Bending	_____ Pulling
_____ Reaching	_____ Lifting	_____ Don't Know
_____ Twisting	_____ Running	_____ Other:_____

5. Is your pain due to an on-the-job injury? (Circle one) Yes No

6. When did you first see a doctor about your pain problem? _____

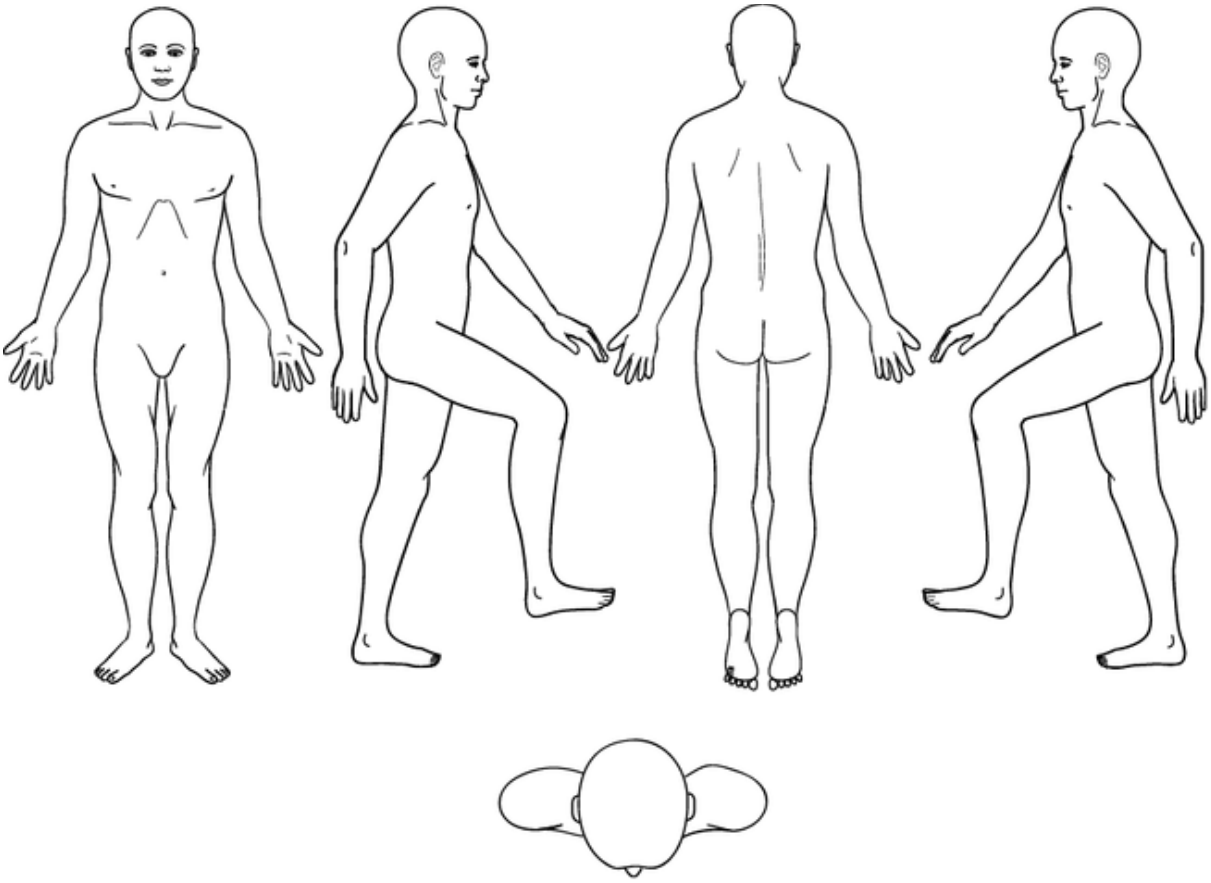
7. How long have you been at your current level of symptoms? _____

This questionnaire provides you with a list of words that describe some of the different qualities of pain and related symptoms. Please put an **X** through the numbers that best describe the intensity of each of the pain and related symptoms you felt during the past week. Use 0 if the word does not describe your pain or related symptoms.

1. Throbbing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
2. Shooting pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
3. Stabbing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
4. Sharp pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
5. Cramping pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
6. Gnawing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
7. Hot-burning pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
8. Aching pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
9. Heavy pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
10. Tender	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
11. Splitting pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
12. Tiring-exhausting	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
13. Sickening	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
14. Fearful	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
15. Punishing-cruel	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
16. Electric-shock pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
17. Cold-freezing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
18. Piercing	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
19. Pain caused by light touch	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
20. Itching	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
21. Tingling or 'pins and needles'	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
22. Numbness	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*

8. Mark the areas on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symptoms indicated below:

Aching	Numbness	Pins & Needles	Burning	Stabbing
>>>	======	*******	XXXXX	///////
>>>	======	*******	XXXXX	///////



9. Circle below to indicate the level of pain:

	No Pain										Worst Pain
The <u>least</u> pain you experience	0	1	2	3	4	5	6	7	8	9	10
The <u>most</u> pain you experience	0	1	2	3	4	5	6	7	8	9	10
Your average level of pain	0	1	2	3	4	5	6	7	8	9	10
Your pain right now as you are filling this out	0	1	2	3	4	5	6	7	8	9	10

10. Does your pain seem to change in location? Y N Location:_____

11. Does your pain occur in separate attacks or episodes? Y N

    If so, how long does each episode last?_____

    How many episodes do you have in a typical day? _____

    If your pain occurs in separate episodes, does it:

    A. Come on slowly and grow more intense with time: Y N

    B. Come on suddenly at full intensity: Y N

12. What causes your pain to increase?

    1. _____ 4. _____
    2. _____ 5. _____
    3. _____ 6. _____

13. Does coughing or sneezing increase your pain? Y N

14. Does sexual activity increase your pain? Y N

15. For women, does your pain change in relationship to menstrual periods? Y N

16. Is your pain worse in the: (Circle) Morning Afternoon Evening

17. Is your pain less in the: (Circle) Morning Afternoon Evening

18. Describe activities or ways you use to prevent or decrease your pain:

    1. _____ 4. _____
    2. _____ 5. _____
    3. _____ 6. _____

19. Do you feel stiff and sore when you get up in the morning? Y N

20. How many times have you been hospitalized for your pain problems? _____

21. How many times have you been to the emergency room for your pain problem?_____

22. When did you last see your physician and what did he/she say about your condition (prognosis and future treatment)?:_____

    _____

23. Please list the physicians, osteopaths, chiropractors, or other health care providers for your pain, along with the approximate dates.

DOCTOR'S NAME TYPE OF DOCTOR CITY / STATE APPROXIMATE DATES

_____

_____

_____

_____

_____

_____

TREATMENT OF YOUR PAIN

1. If you have had surgery for your pain problem, please fill in the following for each operation:

Date	Type of Surgery	Outcome			If better, how long did it take?	How long did it last?
		Worse	Same	Better		
		W	S	B		
		W	S	B		
		W	S	B		
		W	S	B		
		W	S	B		

3. Please list ALL the medications which you are now taking, whether they are for pain or for some other health problem.

Medication	Dosage	#times per day	Prescribing Dr.	Dr.'s Phone#

2. Put a check next to each type of treatment you have had for your pain in the past. Then check the column that best describes the effect of the treatment. If you have had treatments not given on this list, write them in at the bottom and indicate how they affected you.

		EFFECT OF TREATMENT		
TREATMENT	Check if you	Helped	Made things	Didn't do much

	have had this treatment		worse	either way
Hot packs				
Ultrasound				
Ice				
Massage				
Electrical stimulation				
TENS unit for home use				
Body mechanics training				
Strengthening exercises				
Aerobics (e.g., exercise bike)				
Gravity inversion				
Traction				
Bed rest				
Chiropractic treatment				
Osteopathic manipulation				
Biofeedback				
Local (trigger point) injection				
Epidural injections				
Facet joint injections				
Soft back brace				
Rigid back brace				
Acupuncture				
Anti-inflammatory medication				
Narcotic pain medication				
Muscle relaxant medication				
Anti-depressant medication				
Heel lift				
Other:				
Other:				

GENERAL MEDICAL HISTORY

1. Please list any <u>other</u> surgeries you have had:

Surgery	Date

2. Please list any <u>other</u> medical conditions you have had:

Condition	Date	Treatment

3. When was your last complete medical check-up? _____

4. Please check any problems you have had:

___ Blood pressure
___ Headaches
___ Eyes
___ Thyroid
___ Ear / Nose / Throat
___ Stomach
___ Bowels
___ Diabetes
___ Ulcer
___ Heart
___ Chest
___ Lungs
___ Limbs
___ Urinary Tract

5. Check and describe any of the following symptoms you have had in the past year:

	Symptom	Explanation
	Weight loss / gain of 10 lbs or more	
	Loss of appetite	
	Problems with depression	
	Problems with anxiety	
	Difficulty sleeping	
	Unusual stress in home life	
	Unusual stress in work life	

6. Do you smoke tobacco? Yes No If yes, how much?_____

7. Do you smoke marijuana or use marijuana products (e.g., CBD, edibles, etc.)? Yes No

   If yes, how much?_____

8. How many caffeinated beverages do you drink daily? _____

9. How often do you drink alcohol?

___ Not at all
___ Less than once a month
___ 1-3 times per month
___ 1-2 times per week
___ 3-6 times a week
___ Every day

10. How does alcohol affect your pain?_____

11. Please check if you have you ever:

_____ Felt you should cut down on your drinking or drug use
_____ Felt annoyed by others criticizing your drinking or drug use
_____ Felt bad or guilty about your drinking or drug use
_____ Had a drink first think in the morning to steady your nerves or get rid of a hangover
_____ Not applicable

12. Did either of your parents have a problem with alcohol, drugs or medications? Y N

13. Do you consider yourself a victim of physical, emotional or sexual abuse? Y N

14. Have you received care from a mental health professional? Y N

If yes, from whom and dates of treatment:

_____

15. Family History:

Family Member		Living	Deceased	State of Health or Cause of Death
	Is your mother …			
	Is your father …			
	How many brothers:			
	How many sisters:			

VOCATIONAL AND SOCIAL HISTORY

1. Education (last year completed):_____

2. Number of marriages:_____ Number of children: _____

Number of dependent children: _____

3. With whom do you currently live? Check All that apply:

_____ Spouse _____ Other relatives _____ Live alone
_____ Children _____ In-laws
_____ Parents _____ Friends

4. What kind of work were you doing when your pain began? _____

5. Are you currently working? Y N If yes, what kind of work do you do?_____

Who is your employer?_____

6. If you are not currently working, when did you last work?_____

What kind of work were you doing?_____

Has your employer treated you fairly?_____

7. Has anyone in your family been on disability? Y N

If yes, what was their relationship to you?_____

8. Have you talked with a vocational counselor since your pain problem began? Y N

If so, who was the counselor (location if possible):_____

9. Are you receiving time loss compensation? Y N

If so, how much per month? _____

10. Are you receiving disability income? Y N

If so, how much per month? _____

11. Compared to your family's income before your pain problem began, is your income now:

_____ Less than 50% of the pre-pain income
_____ 50-75% of the pre-pain income
_____ More than 75% of the pre-pain income

12. Is there currently any legal action related to your pain problem? Y N
Has there been legal action in the past due to an injury or illness? Y N

13. Have you served in the Military? Y N If yes, branch of service and job:

_____

If yes, were you honorably discharged? Y N
Do you have a service–related disability? Y N If so, what percent?_____

14. Have you ever been in jail? Y N
If yes, please give dates and reason:_____

15. If this is an on-the-job injury, has the Workers' Compensation claim ever been closed? Y N

16. Do people usually know that you are in pain without you having to tell them? Y N
How do they know?_____
Do you try to hide your pain from your family? Y N
From friends or acquaintances? Y N

17. How many hours do you sleep per 24 hours? _____ Hours

How well do you sleep with medication (check one):

_____ Sleep well
_____ Sleep fairly well
_____ Sleep poorly due to pain
_____ Sleep poorly due to reasons other than pain

18. Circle the number to indicate how much of a problem you hare having with each of the following:

	None										Severe
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

18. Please check the category that best describes the effect of pain on each activity listed:

	I do this without pain.	I tend to do this despite the pain.	I tend to avoid this activity.
PERSONAL ACTIVITIES			
Wash/comb hair			
Dress self			
Put on socks/shoes			
Use bath tub			
Sexual activity			
HOUSEHOLD TASKS			
Sweeping			
Mopping			
Vacuuming			
Bed Making			
Standing at kitchen sink			
Cooking			
Getting things in/out of oven			
Washing windows			
Load/unload dishwasher			
Removing clothes from washer/dryer			
Cleaning tub			
Climbing stairs			
Mowing lawn			
Raking			
CAR ACTIVITIES			
In and out of front seat			
In and out of back seat			
Driving			
Riding			
Getting groceries in/out			

19. What recreational activities have you given up because of your pain problem? _____
_____

20. What recreational activities do you still pursue despite your pain problem? _____
_____

21. What do you want improved most by treatment (spinal cord stimulator / pain pump)? Please number in order of preference.

____ Medication usage
____ Pain relief
____ Job activities
____ Household activities
____ Recreational activities
____ Mood
____ Relationships with others
____ Other _____

22. What would you do if you had no pain?_____

23. What kind of work/activities would you like to do in the future?_____

24. Please circle T or F to indicate whether these statements are true or false for you.

1.	I am disappointed with the medical profession.	T	F
2.	I believe there is a specialist somewhere who can solve this pain problem.	T	F
3.	I am annoyed that doctors have not helped me.	T	F
4.	I have trouble getting doctors to take me seriously.	T	F
5.	Some doctors have said or hinted that my pain is imaginary.	T	F
6.	Nurses and doctors sometimes act as if I am faking.	T	F
7.	There is nothing more that I can do to improve my condition.	T	F
8.	I often feel tired, even with little or no activity.	T	F
9.	I frequently lay down because of pain or fatigue.	T	F
10.	As soon as one pain problem resolves, another one appears.	T	F
11.	For much of my life I have suffered from painful illnesses or injuries.	T	F
12.	Except for my pain problem, there are no other problems in my life.	T	F
13.	My pain problem developed just when things were going well for a change.	T	F
14.	My family has drawn closer together to help cope with my pain.	T	F
15.	Sometimes it is hard for me to think about anything except the pain.	T	F
16.	I find it hard to say “no” to people.	T	F