

## PATIENT HISTORY QUESTIONNAIRE

Height \_\_\_\_\_ Weight \_\_\_\_\_

What problem are you seeing us for today?  
\_\_\_\_\_  
\_\_\_\_\_

Are you still working?  Yes  No

Last day on the job? \_\_\_\_\_

How did pain start? (check all that apply)

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> suddenly    | <input type="checkbox"/> pulling               |
| <input type="checkbox"/> gradually   | <input type="checkbox"/> injured at work       |
| <input type="checkbox"/> lifting     | <input type="checkbox"/> auto accident         |
| <input type="checkbox"/> twisting    | <input type="checkbox"/> hit from behind       |
| <input type="checkbox"/> fall        | <input type="checkbox"/> during sport activity |
| <input type="checkbox"/> bending     | <input type="checkbox"/> no apparent cause     |
| <input type="checkbox"/> other _____ |  |

What activities make the pain worse?

- |  |  |
|--|--|
| <input type="checkbox"/> exercise (during) | <input type="checkbox"/> bending forward   |
| <input type="checkbox"/> exercise (after)  | <input type="checkbox"/> bending backward  |
| <input type="checkbox"/> sitting           | <input type="checkbox"/> coughing          |
| <input type="checkbox"/> standing          | <input type="checkbox"/> sneezing          |
| <input type="checkbox"/> walking           | <input type="checkbox"/> physical activity |
| <input type="checkbox"/> other _____       |  |

Is pain constant?  Yes  No

Activity affect pain?  Yes  No

If so, does it make it  Worse  Better

Does the pain radiate?  Yes  No

If so, where? \_\_\_\_\_

What reduces pain?  exercise

- |  |   |
|--|---|
| <input type="checkbox"/> lying down        | <input type="checkbox"/> pain pills       |
| <input type="checkbox"/> sitting           | <input type="checkbox"/> injections       |
| <input type="checkbox"/> standing          | <input type="checkbox"/> muscle relaxants |
| <input type="checkbox"/> walking           | <input type="checkbox"/> aspirin          |
| <input type="checkbox"/> anti-inflammatory | <input type="checkbox"/> manipulation     |
| <input type="checkbox"/> nothing           | <input type="checkbox"/> physical therapy |
| <input type="checkbox"/> other _____       |   |

How long had you had this pain?

\_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

How long have you had similar pain?

\_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

Have you had surgery for this problem?

Yes  No Number of times? \_\_\_\_\_

Dates: \_\_\_\_\_

Have you had these diagnostic studies?

	Yes	No	Date
Diagnostic x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electromyogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are studies with you	<input type="checkbox"/>	<input type="checkbox"/>	

Have you been hospitalized for your pain problem?

yes  no Dates: \_\_\_\_\_

Have you been hospitalized for other medical problems?

yes  no Number of times \_\_\_\_\_

Describe \_\_\_\_\_  
\_\_\_\_\_

What medications are you currently taking?  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following conditions?

- |  |   |
|--|---|
| <input type="checkbox"/> stomach problem     | <input type="checkbox"/> cancer                 |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> heart problems         |
| <input type="checkbox"/> arthritis           | <input type="checkbox"/> emotional upset        |
| <input type="checkbox"/> gout                | <input type="checkbox"/> hypertension           |
| <input type="checkbox"/> weight loss         | <input type="checkbox"/> epilepsy               |
| <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> bowel/bladder problems |
| <input type="checkbox"/> weakness            | <input type="checkbox"/> numbness or tingling   |
| <input type="checkbox"/> other _____         |   |

Do you have any allergies to medication?  Yes  No

List: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcoholic beverages?

Yes  No How much? \_\_\_\_\_

What other types of doctors or health care providers have you seen for this condition? \_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_