

PATIENT INFORMATION QUESTIONNAIRE

PATIENT NAME _____ **BIRTH DATE** _____ **AGE** _____

Referred to this office by: _____

Are you: right or left hand dominant?

HISTORY OF PRESENT ILLNESS

When did your pain originally begin? _____

If you have arm or leg pain, when did it begin? _____

When did your current episode begin? _____

Did your pain begin gradually suddenly injury/date _____

If "injury," did injury occur at work auto accident other

If "other," please explain _____

Describe injury _____

Have you had back surgery? yes no If yes, date: _____

Have you had neck surgery: yes no If yes, date _____

If you have had:	Was it helpful?		Last Date
	Yes	No	
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chiropractic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If Yes, type and how many _____			
TENS Unit?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any
 numbness or tingling in the right or left arm?
 right or left leg?
 weakness in the right or left arm?
 right or left leg?

Have you had any changes in bowel or bladder function: yes no

If Yes, please describe _____

What time of day is your pain worse? morning afternoon night all day
 upon awakening during sleep

Does your pain occur: continuously frequently occasionally rarely

Which of the following are you currently able to perform?

- bathe and dress independently light housework
 light shopping your usual work

Describe your usual recreational activities _____

What activities are you unable to do because of your pain? _____

How do the following affect your pain? Better Worse No Different

Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Side with Knees Bent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awake in AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How long can you sit at one time? _____

How long can you stand at one time? _____

How long can you walk? _____ How far? _____

How much can you comfortably lift? _____ lbs.

Have You Had: Yes No Approximate Date

X-rays?	<input type="checkbox"/>	<input type="checkbox"/>	_____
CAT Scan?	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI?	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PERSONAL HISTORY

Are you: married single separated divorced widowed

Are you currently working: yes no
If Yes, are you working at full duty light duty

What (is/was) your (current/previous) job? _____
(circle one) (circle one)

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

Is your quality of sleep: good fair poor

Do you feel depressed: no mildly moderately severely

Do you smoke: yes no If Yes, how much? _____

Do you drink alcoholic beverages: yes no
If Yes, do you drink daily rarely occasionally

What is your height? _____ What is your weight? _____

Has there been a change in your weight in the last 3-6 months? yes no
If Yes, was this a: gain loss How much? _____

Do you have any additional information which would be helpful to understand your problem?

Do you have an attorney helping you in this matter? yes no

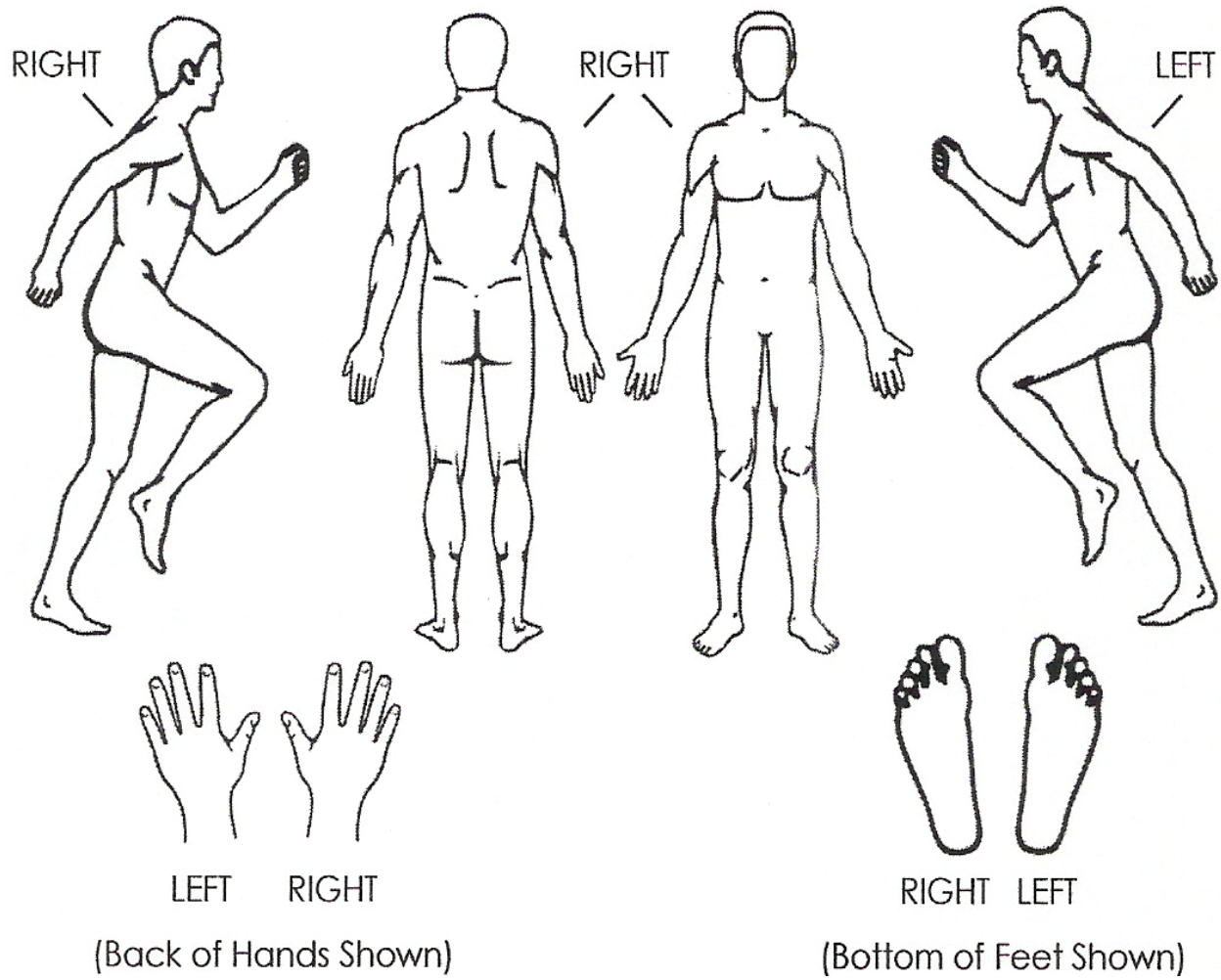
Are you on Disability compensation? yes no

List any medications you have taken in the past for your pain:

_____	_____
_____	_____
_____	_____
_____	_____

PLEASE SHADE IN THE AREAS WHERE YOU FEEL PAIN AND/OR NUMBNESS:

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
A	B	N	P	S	O (troublesome, shooting, stubborn, gnawing, sharp)



Please rate your pain:	0 = no pain					10 = the worst pain you can imagine					
1. Right Now	0	1	2	3	4	5	6	7	8	9	10
2. At Its Worst	0	1	2	3	4	5	6	7	8	9	10
3. At Its Best	0	1	2	3	4	5	6	7	8	9	10
4. On Average	0	1	2	3	4	5	6	7	8	9	10