

Patient Questionnaire

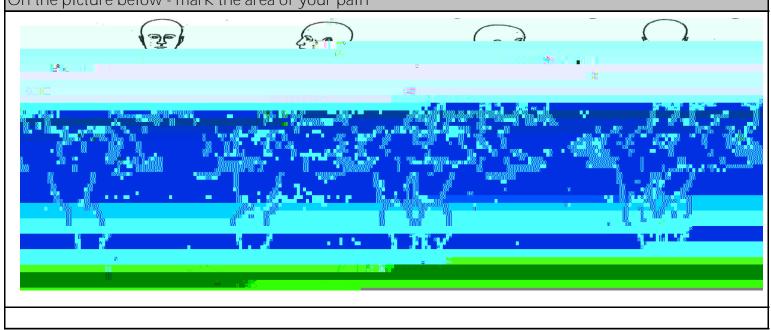
Patient Identification Sticker

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Pain Treatment Center

PLEASE FILL OUT AND BRING WITH YOU TO YOUR FIRST APPOINTMENT. BE SURE TO INCLUDE A LIST ALL YOUR MEDICATIONS AND ANY X-RAY/MRI IMAGING RELATED TO YOUR PAIN.

Whe	en did your pain begin: Month Year		
Describe how your pain started (ex. Accident, lifting, surgery, following an illness):			
The	Pain (Please Check One):		
	Only occurs under certain circumstances		
	Is rarely present		
	Is usually present		
	Is always present		
Since	e the beginning of the present problem, has the intensity of the pain (Please Check One)		
	Been variable		
	Remained the same		
	Decreased		
	Increased		
	Unknown		
Pleas	se indicate on a scale of 1 - 10 intensity of your pain. 0 being NO PAIN, 10 being VERY SEVERE PAIN		
	Your pain right now		
	The average intensity of your pain this week		
	Your pain at its worst in the last week		
	Your pain at its least in the last week		
0 - 1	handa a la la constitución de la		
On the picture below - mark the area of your pain			



Yes No Yes No

A cupuncturist A nesthesiologist Biofeedback

Cardiologist Chiropractor

Cleryman Dentist

Dermatologist

ENT Specialist Endrocrinologist

Faith Healer

General/Family Practitioner

Herbal Remedies

Hypnotist Internist

Massage Therapist

Neurologist Ophthalmologist Pediatrician

Physi. 22 Therapyst

Psychologist Radiologist Reflexology

Relaxation Training Social Worker (MSW)

Surgeon Urologist Other

Treatments

Anit-inflamatory
Epidural Injection
Facet Joint Injections

Muscle Relaxant

Narcotic Pain Medication

Pool Therapy SI Injections Spine Surgery



Contrast Allergies (If yes describe reaction) - Y

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Medications

Current Pain Medications							
Medication	Dosage	How Many/ Da	Reason for Taking	Who Prescribes			
Current Other Medications (Include ov	er-the-count	er medication	is)				
Medication	Dosage	How Many/ Da	Reason for Taking	Who Prescribes			
Allergies							
Medications (List with Reaction)							
Latex Allergies (If yes describe reaction) - Y N							

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No	Past Medical History		
	Diabetes, high blood sugar		
	Hypertension, high blood pressure		
	Hyperlipidemia, high cholesterol or triglyceride		
	Cardiovascular (heart or blood vessel) disease		
	Stroke or TIA		
	Thyroid disease		
	Parathyroid disease or high blood calcium		
	Pituitary disease		
	A drenal disease		
	Gonadal disease		
	Other (please list)		
	Please List Prior Surgeries		
No	Family History		
	Diabetes, high blood sugar		
	Hypertension, high blood pressure		
	Hyperlipidemia, high cholesterol or triglyceride		
	Cardiovascular (heart or blood vessel) disease		
	Thyroid disease		
	Other hormonal diseases		
	Drug Use (Past or Present)		
	Alcohol Use (Past or Present)		
	Other (please list)		
	Personal History		
ıt is y	our marital status?		
	Single		
	Married		
	Seperated		
	Divorced		
	Widowed		
	whom do you live?		
iber c	ber of children:		
	Ages		

Patient Questionnaire

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Pain Treatment Center

Yes	No	Work History
		Are you currently working?
	If no, are you applying for compensation?	
Are you involved in legal action regarding your pain? Would you like to return to the work force?		Are you involved in legal action regarding your pain? Would you like to return to the work force?

Yes No		Social History
	Do you or have you smoke/d?	
	Do you or drink alcohol?	How much?
	Have you used alcohol in the past?	
	Do you use recreational drugs?	
	Have you used drugs in the past?	
	Do you engage in hazardous activities?	

Poor general health recently Recent weight change, loss of appetite Fever, chills, profuse sweating Fatigue, lethargy, malaise

Recent eye disease, injury or surgery Blurred vision, double vision, loss of vision Pain in the eyes Eye examination within the last year

Hearing loss or ringing in the ears
Ear pain or discharge
Chronic or recurring sinus problems
Chronic or recurring sores in the nose/ mouth
Chronic or recurring dental problems
Chronic or recurring sore throat

Chest pain
Rapid or irregular heartbeat, palpitations
Sudden loss of consciousness, fainting
Shortness of breath with exertion
Swelling of the feet, ankles or hands

Chronic coughing
Coughing up blood
Chronic wheezing, asthma
Chronic shortness of breath

Recurring nausea and vomiting, vomiting blood Abdominal pain Chronic or recurring diarrhea or constipation Bloody bowel movements Jaundice, liver disease

Frequent or painful urination

Joint pain, stiffness or swelling
Muscle pain, weakness or cramping
Limitation of motion, difficulty walking
Chronic neck or back pain
Chronic foot pain or deformity

Chronic or recurring rashes or sores
Suspicious moles or skin lesions
Hair loss, change in nails
Breast pain, breast lump or nipple discharge

Frequent or recurring headaches
Dizziness, lightheadedness
Seizures or convulsions
Loss of sensation or muscle strength
Stroke or head injury
Memory loss, confusion
Tremor

Nervousness or anxiety Chronic depression Inability to concentrate Sleep problems

Excessive thirst or urination
Heat or cold intolerance
Unexplained change in skin pigmentation
Change in hat or ring size
Loss of height
Unexplained bone fractures

Recurring nosebleeds, bleeding gums, bruising Chronic anemia, recent transfusion Swollen lymph nodes Recurring infections