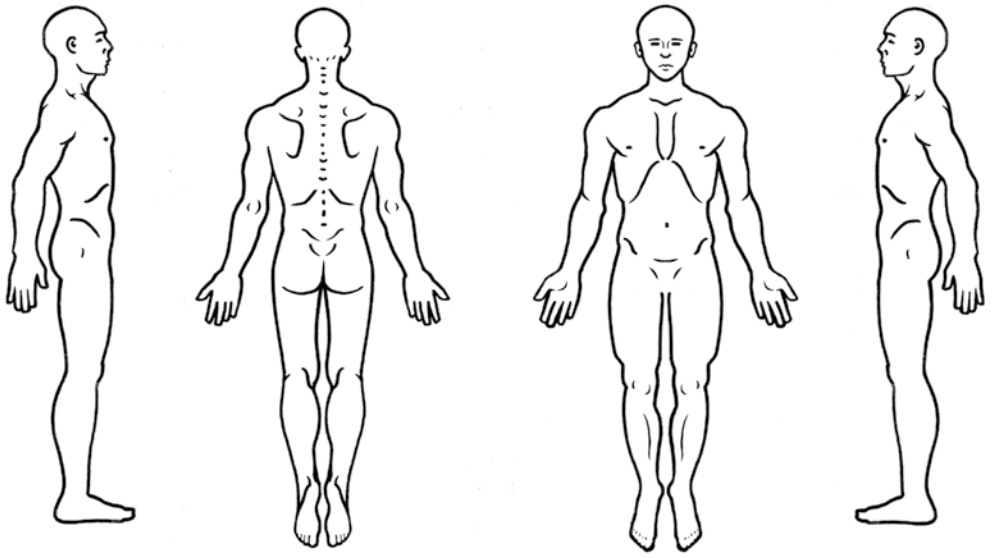
# PATIENT QUESTIONAIRE

Name: _____ Today's date_____
Date of Birth: _____ Age: _____ Date your problem began_____

PAIN LOCATION **Use key at right to fill in body → → → → →**




PAIN SEVERITY SCALE

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | Mild | | Annoying Discomfort | | Distressing Miserable | | Agonizing Horrible | | Excruciating Unbearable | |

**Choose the number of the word above which best describes the following:**
____Your pain right now
____Your pain at its worst
____Your pain at its least

**Frequency of Pain: Check one**
_____Infrequent/Transient
_____Occasional
_____Constant/ Continuous

1. What is your present problem? _____
2. How did this problem start? _____
   _____
3. Please list anything you feel important or of interest to your current problem or pain:_____
   _____
   _____
4. Is your pain worse at any particular time of day? ___Yes. ___ No. If yes, when_____
5. What aggravates your pain? ___At rest ___Sitting ___Standing ___Awakens me
   ___Sneezing/Coughing ___Working ___Walking ___Sexual Intercourse
   ___All the time ___ Lifting ___Other (please specify)_____
6. What relieves your pain? ___Sitting ___Lying down ___Medications __Heat ___Ice
   ___traction ___massage ___walking ___Other (please specify)_____
7. Do you have difficulty sleeping? ___ Yes ___No Sleep position _____
8. At the present time are you getting: ___Better ___ Worse ____Stable
9. At the present time would you say your health is: __Excellent __Very good __ Fair __Poor
10. Do you have a Neurostimulator implant to control pain? ___Yes ___No

# PATIENT QUESTIONAIRE

11. Do you (or have you recently) Suffered from any of the following?
    ___Numbness ___Malaise ___ Nausea/Vomiting ___ Dizziness
    ___Weakness ___Fatigue ___Fever/Chills/Sweats ___ Unexplained weight loss/gain
12. Are you or might you be pregnant? ___Yes ___ No
13. Have you ever been diagnosed with or treated for any of the following conditions?
    ___Epilepsy/Seizures ___Liver disease ___Respiratory problems Type:_____
    ___Osteoporosis ___Diabetes ___Heart Problems Type: _____
    ___Arthritis ___Thyroid problems ___Cancer Type: _____
    ___High Blood Pressure ___Kidney problems ___Physical Disability
    ___Depression ___Neurological disorder (MS, stroke, Parkinson's) Other:_____
    ___Chemical Dependency (Alcoholism, Other) Other:_____
14. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
    ___Heart problems ___Diabetes ___Cancer ___ Headaches
    ___Stroke ___Mental illness ___Kidney Disease ___Liver Disease
    ___High Blood Pressure ___Osteoporosis ___Arthritis ___Physical Disability
15. Prior surgeries and approximate dates: _____
    _____
    _____
16. Have you seen any of the following medical personnel in the past 3 months?
    a. Doctor or nurse practitioner: ___ Yes ___No Reason: _____
    b. Osteopath: ___Yes ___No Reason: _____
    c. Chiropractor ___Yes ___No Reason: _____
    d. Psychiatrist/Psychologist ___Yes ___No Reason: _____
    e. Other Reason: _____
17. Have you had physical therapy before? __Yes __No If Yes, was it for your current problem? __Yes __No
18. What treatment during physical therapy helped? (exercise, manipulation, traction, cold/hot packs, etc.)
    _____
19. Recent Diagnostic Studies: __X-Rays __MRI __CT Scan __EMG __Ultrasound
    Results:
    _____
20. Type of medical equipment used at home or in the community (walker, cane, oxygen, etc.)_____
21. Leisure activities, sports, hobbies,
    exercise:_____
22. Employment/Work (check all that apply): ___Full-time ___Part-time ___Light duty ___Unemployed
    ___Retired ___Student ___Homemaker ___Work with modification in job duty due to present problem
    ___Not working due to present problem
23. Occupation (title, type): _____
24. Where do you live (house, apartment, nursing home, etc.)? _____
25. With whom do you live (alone, spouse/significant other, child, etc.)?_____
26. Do you have any concerns about your safety at home or in any of your relationships? _____
26. Do you drink caffeinated beverages? ___Yes ___No How many drinks per day? _____
27. Any new life stresses? _____
    _____
28. Medications: **Please complete additional document.**

**Please complete both sides**