MUSCULOSKELETAL QUESTIONAIRE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

The following is very important in our evaluation process. Please answer these questions as specifically as possible to provide us with a clear picture of your present pain and functional status.

Are you currently taking any medications? □ Yes □ No If yes, please list: _____

_____

_____

Are you currently taking any aspirin, ibuprofen, minerals, herbs or nutritional supplements? □ Yes □ No

If yes, please list: _____

Are you currently experiencing any of the following?

Fever	□ Yes	□ No	Swelling in your arms or legs	□ Yes	□ No
Unintentional weight loss/gain	□ Yes	□ No	Bladder or bowel incontinence	□ Yes	□ No
Night sweats	□ Yes	□ No	Numbness/anesthesia in your groin	□ Yes	□ No
Difficulty walking	□ Yes	□ No	Severe headache	□ Yes	□ No
Severe neck pain	□ Yes	□ No	Dizziness or visual disturbances	□ Yes	□ No

Are you have any of the following?

Pacemaker	□ Yes	□ No	Cochlear implant	□ Yes	□ No
Implanted spinal stimulator	□ Yes	□ No	Other: _____		

What is the primary issue or problem that brings you in today? (check all that apply)

□ Lower back pain	□ Shoulder pain	□ Thoracic/mid back
□ Neck pain/headaches	□ Wrist/hand pain	□ Knee pain
□ Hip pain	□ Elbow pain	□ Foot/ankle pain

When did your symptoms begin? _____

Did anything cause or start the pain? (accident, illness, or injury?) □ Yes □ No

If yes, please describe: _____

Have you had previous surgery for this condition? □ Yes □ No Date: _____

Type of surgery: _____

Other surgical history: _____

_____

Does the pain or symptoms radiate into your hips or legs? □ Yes □ No

Does the pain or symptoms radiate into your arms? □ Yes □ No

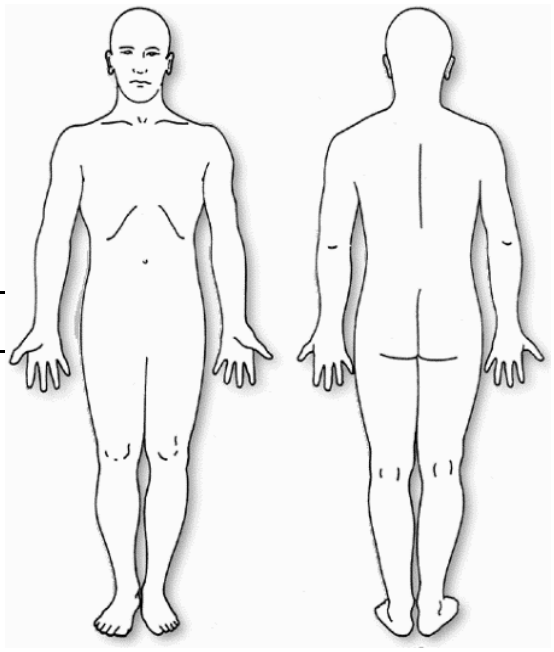
Have you had imaging (MRI, X-ray, etc.) for this condition? □ Yes □ No

Have you had interventional pain management (epidural steroids or steroid/cortisone shots) for this condition? □ Yes □ No

Type: _____

Date: _____

Please shade in areas of pain/concern:



Please describe your pain:

- □ Burning
- □ Dull
- □ Electric Shock
- □ Sharp
- □ Crawling
- □ Ache
- □ Spontaneous
- □ Intermittent
- □ Relieved by posture or movement pattern

Please rate your pain in the last 24-72 hours using the "0-10" scale where 0 is no pain and 10 is worst:

At its worst: _____ At its best: _____ At present: _____ When sleeping: _____

When are your symptoms the worst? _____

When are your symptoms the best? _____

What activities increase your pain? _____

What activities decrease your pain? _____

Please describe your goals and expectations: _____

To the best of my knowledge, the information on the form is accurate. I understand that providing false information can be dangerous to my health. It is my responsibility to inform Regen Rx of ***any*** changes to my medical history.

Signature: _____ **Date**: _____

Reviewed by: _____ **Date**: _____