PATIENT HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Occupation: _____ Date: _____

1. When (roughly what date) did your present pain start?

   _____

   Are you still working?

   ☐ Yes ☐ No Last day on job _____

2. How did pain start? (check appropriate box)

   ☐ Suddenly
   ☐ Gradually
   ☐ Lifting
   ☐ Twisting
   ☐ Fall
   ☐ Bending
   ☐ Pulling
   ☐ Injured at work
   ☐ Injured in auto accident
   ☐ Hit from behind
   ☐ Injured during sports
   ☐ No apparent cause

3. What activities make the pain worse?

   ☐ Exercise (during)
   ☐ Exercise (after)
   ☐ Sitting
   ☐ Standing
   ☐ Walking
   ☐ Bending forward
   ☐ Bending backward
   ☐ Coughing
   ☐ Sneezing

4. What reduces the pain?

   ☐ Lying down
   ☐ Sitting
   ☐ Standing
   ☐ Walking
   ☐ Manipulation
   ☐ Exercises in physical therapy
   ☐ Pain pills
   ☐ Injections for pain
   ☐ Muscle relaxant pills
   ☐ Aspirin or anti-inflammatory pills
   ☐ Nothing
   ☐ Other _____

5. How long have you had this pain?

   _____ years _____ months _____ weeks

   How long have you had similar pain?

   _____ years _____ months _____ weeks

6. Have you had any of these diagnostic studies?

	Yes	No	Date
Diagnostic x-rays	☐	☐	_____
CT (computed tomography) scan	☐	☐	_____
Myelogram (x-ray with dye injection)	☐	☐	_____
Electromyogram (EMG)	☐	☐	_____
Discogram	☐	☐	_____
MRI (magnetic resonance imaging)	☐	☐	_____
Arthrogram or sonogram	☐	☐	_____
Injections	☐	☐	_____

7. Have you been hospitalized for your pain problem?

   ☐ No ☐ Yes

   Number of times _____ Dates _____

8. Have you had surgery for this problem? ☐ No ☐ Yes

   Number of times _____ Dates _____

9. Have you been hospitalized for other medical problems?

   ☐ No ☐ Yes

   Number of times _____ Describe _____

   _____

10. What medications are you currently taking? _____

    _____

    _____

11. Do you take antacids? ☐ Yes ☐ No

12. Do you have any of the following conditions?

    ☐ Stomach problems
    ☐ Diabetes
    ☐ Arthritis
    ☐ Gout
    ☐ Sexual difficulties
    ☐ Bowel or bladder problem
    ☐ Cancer
    ☐ Heart
    ☐ Epilepsy
    ☐ Weight loss
    ☐ Other (please explain) _____

13. Do you have allergies? to medications?

    ☐ No ☐ Yes Please list: _____

    _____

14. Do you smoke? ☐ No ☐ Yes How much? _____

15. Do you drink alcoholic beverages?

    ☐ No ☐ Yes How much? _____

16. What other types of doctors or health care providers have you seen for this condition? _____

    _____

17. Do you want a report sent to your attorney?

    ☐ Yes ☐ No ☐ I have no attorney

18. Do you have any additional information that would be helpful in understanding your problem? _____

    _____

19. Please indicate last grade completed in school _____

20. To be sure paperwork is filled out correctly, please check if appropriate:

    ☐ On workman's compensation
    ☐ Report should be sent to referring physician or family physician
    ☐ Receiving disability income
    ☐ Legal proceeding pending
    ☐ Report should be sent to another party

    Name _____

    Address _____

21. Do you plan to be at your regular job in 6 months?

    ☐ Yes ☐ No