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Health History and Pain Questionnaire

THIS FORM MUST BE RETURNED 10 DAYS BEFORE YOUR APPOINTMENT OR YOUR APPOINTMENT WILL BE AUTOMATICALLY CANCELLED!!

Thank you for completing the following questionnaire. The questions asked and your thorough response is critically important in developing a treatment plan specifically for you.

Name: _____

Birthdate:_____Current Age:_____Date Completed: _____

Address: _____

City: _____State:_____Zip:_____

Phone (Home):(_____)_____Work:(_____)_____

Cell Phone: _____Email:_____

Primary Care Physician: _____ Referring Physician: _____

Address: Address:

_____ _____

Phone: Phone:

_____ _____

Height: _____ Weight: _____ Weight one year ago: _____

Do you have, or are you trying to open a workmen's Compensation or L&I claim?
Yes:_____ No:_____

If yes, please complete this section. If no, continue to the next page.

. Who is your Primary Treating Physician:_____

2. Are you represented by an attorney: Y/N Name: _____
Address: _____ Phone: _____

3. Status: Please indicate the date of determination for the following: _____
( ) Temporary Total Disabled ( ) Permanent and Stationary
( ) Disability Rating _____ ( ) Medically Rated _____

4. If you have settled your claim, do you have future medical care: Yes/No

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Domestic Partner
How would you describe yourself?
Aleutian Asian Black/African
Middle Eastern White/Caucasian Hispanic/Latino
Other (specify): _____

Hand Dominance: ( ) Right-handed ( ) Left-handed ( ) Ambidextrous

What is your present or most recent occupation:
_____

Current Employment/Date last worked: _____
( ) Full time ( ) Part time ( ) Retired
( ) Homemaker ( ) Unemployed due to pain
( ) Unemployed for other reasons (Specify)
_____

With whom do you live: _____Relationship:_____

Do they work outside of the home Y/N If so, employer/occupation:_____
What is the highest grade you completed:
( ) Less than High School ( ) High School ( ) College ( ) Graduate School
( ) Other _____

What are your present sources of financial support: (Check all that apply)
( ) Salary/Employment Income ( ) Savings
( ) Disability ( ) Workers Compensation
( ) Insurance ( ) Other: _____

Pain History:
1. What is the problem for which you were referred (Chief complaint):_____
2. What is the date that your pain began: _____
3. How were you injured/ How did your pain develop: _____
( ) Work related ( ) Auto accident ( ) Accident at home
( ) Following an illness ( ) Following surgery ( ) Pain began spontaneously
( ) Lifting ( ) Twisting ( ) Falling
( ) Other: _____

Please describe the onset and circumstances of your pain: _____
_____
4. Have you changed the type of work or given up your job due to your pain: ( ) Yes ( ) No

5. If unemployed, what is the last date you worked:_____

6. Are there any legal action pending as a result of this problem: ( ) Yes ( ) No If yes, please specify (i.e. auto accident):_____

7. What does your pain feel like: (Circle all that apply)

Pulsing	Throbbing	Pounding	Jumping	Shooting	Pricking	Stabbing
Sharp	Pinching	Gnawing	Cramping	Tugging	Pulling	Hot Burning
Tingling	Stinging	Dull	Aching	Heavy	Tender	Spreading
Radiating	Numb	Squeezing	Cool	Cold	Nagging	Agonizing
Tiring	Exhausting	Sickening	Suffocating	Other: _____		

8. What kinds of feelings accompany your pain: (Circle all that apply)

Fearful	Frightened	Terrified	Punished	Anger
Guilt	Depressed	Anxiety	Frustration	

9. How often does your pain occur: (choose one) ( ) Continuously ( ) Several times a day ( ) Once a day ( ) Several times a week ( ) Several times a month ( ) Once a month ( ) Less frequent that once a month ( ) Never ( ) Other:_____

10. How often does your pain **interfere** with your activities: ( ) Continuously ( ) Several times a day ( ) Once a day ( ) Several times a week ( ) Several times a month ( ) Once a month ( ) Less frequent that once a month ( ) Never

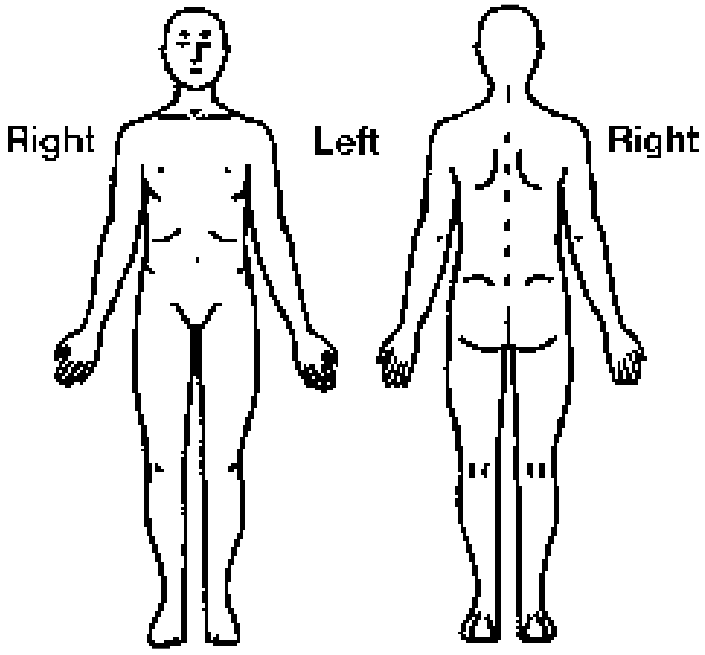
11. Is your pain: (choose one) ( ) Getting better ( ) Getting worse ( ) Staying the same

12. Choose **one** word group that best describes your pain pattern: ( ) Continuously, steady, constant ( ) Rhythmic, periodic, intermittent ( ) Brief, momentary, transient

13. What makes your pain worse: _____

14. What makes your pain better: _____

15. Mark the location of your pain



16. Review the statements indicating and describing the area of your pain:

	Yes	No
Extreme sensitivity to touch		
Weakness		
Deceased Sensation		
Joint tenderness and stiffness		
Decreased range of motion		
Swelling or edema		

17. We are interested in two main aspects of your pain experience: The intensity of the pain (how strong it is) as well as how disturbing or bothersome the pain is. Please indicate the **range** (lowest and highest) on each scale:

Pain Intensity
Low "0" _____ "10" High
Pain Disturbing
Low "0" _____ "10" High
Activity Scale

Bed ridden	Limited self-care/chores	Light duty work	Home chores	Full time work	All activities
5%	20%	50%	70%	90%	100%

18. In general, how likely do you feel that your pain will be removed or cured: (Circle one)
Impossible Unlikely Uncertain Likely Certain

19. If the worst pain you ever experienced is a TEN and no pain is ZERO, what is your **current** pain level: _____

20. If it is not possible to completely alleviate your pain, what would be an acceptable level of pain on a scale of ZERO to TEN: _____

21. If your pain were reduced to an "acceptable level" for you, list the kinds of activities you would engage in that your current pain level prevents you from doing: (Be specific)
_____
22. How many times this year have you been to the emergency room because of a pain problem: _____
Please describe: _____

23. How many times this year have you been admitted to a hospital for any problem associated with pain:_____

24. Has anyone in your family ever had a chronic pain problem: Y/N If yes, please describe_____

25. Most people have seen one or more other doctors or other practioners before coming to our office.

Indicate any practioners who have prescribed pain medicine for you in the last 3 years. Please list their names and telephone numbers below. (Include Emergency Room visits and other providers not on the list.):

( ) Acupuncture	( ) Anesthesiologist	( ) Bio Feedback	( ) Chiropractor
( ) General Practice	( ) Hypnotist	( ) Herbologist	( ) Internal Medicine
( ) Massage Therapist	( ) Naturopath	( ) Neurologist	( ) Neurosurgeon
( ) Nutritionist	( ) Osteopath	( ) Orthopedist	( ) Podiatrist
( ) Physical Therapy	( ) Psychiatrist	( ) Psychologist	( ) Surgeon

_____

_____

_____

Past Medical History:

1. Are you otherwise in good health: Y/N If no, please describe:

_____

2. When was your last routine physical exam: _____ By whom: _____
If applicable: Last Pap smear: _____ Mammogram (or exam): _____

3. Have you ever been diagnosed with any form of Hepatitis? Y/N If yes, describe:

_____

4. Do you currently have or ever had (Include the approximate year of diagnosis and a description)

Condition	Yes	No	Approximate year of diagnosis and description
Heart Disease			
Lung Disease			
Kidney Disease			
Liver Disease			
Thyroid Disease			
High Blood Pressure			
Bleeding Tendencies			
Anemia			
Stroke			
Cancer			
Seizures			
Diabetes			
Arthritis			
Ulcers			
Emotional Problems			
Other			

5. Hospitalizations/Operations: Please list any previous hospitalizations/operations.
Hospitalization Year Complications

_____

_____

_____

_____

_____

Operation Year Complications

_____

_____

6. Please list and describe any past or current serious illnesses or injuries not already covered:

_____

_____

7. Have you had any problems with surgery/anesthesia in the past: _____

8. Do you have any allergies to medicines: _____

9. Do any medications make you sick: _____

10. Describe your reaction: _____

Present Medications

Please list **ALL** medications you are currently taking, dose and frequency. Include all medications including aspirin, lotions, skin patches, supplements etc. (Please use back of the page if you require more space)

Medication Name	Dose and Frequency	Degree of Relief and Side Effects

Past Medications

Medication Name	When taken/How long ago	Why it was stopped

Personal Habits

1. Do you use Tobacco: Type _____ Amount/Day _____ # of Years _____
If not currently, how much in the past: _____

2. Do you use Alcohol: Type _____ Amount/Day _____ # of Years _____
If not currently, how much in the past: _____

3. Do you use Marijuana: Type _____ Amount/Day _____ # of Years _____
If not currently, how much in the past: _____

4. Do you use recreational drugs: Type _____ Amount/Day _____ # of Years _____
If not currently, how much in the past: _____

5. Are you currently or have you been involved in a drug or alcohol rehabilitation program including twelve steps programs: ( ) Yes ( ) No If yes, please describe: _____
(All responses will be kept confidential)

6. Are you on a special diet: ( ) Yes ( ) No Please describe _____

7. Do you exercise on a regular basis: ( ) Yes ( ) No Please describe _____

Family History

Family Member	**Living**		**Age**	**Medical Problems or Cause of Death**
	YES	**NO**		
Father:				
Mother:				
Siblings:				
Children:				

Review of Systems (Circle all that apply)			
Eyes:	Blurred vision	Pain	
Nose:	Nose Bleeds	Nasal congestion	Runny nose
Throat:	Sore throat	Difficulty swallowing	Hoarseness
	Burning in back of throat		
Oropharynx:	Dentures Full / Partial		
Heart:	Chest Pain	Previous heart attack	Dizzy spells
	Congestive heart failure last six months		
Lungs:	Wheezing	Short of breath	Smoke
	Asthma	environmental allergies	
GI:	Indigestion	Abdominal pain	Nausea/Vomiting
	Dark Stools	Jaundice	Rectal bleeding
	Incontinence	Change in bowel function	
GU:	Pain with urination	Frequent urination	Blood in urine
	Incontinence	Frequent urination at night	
Musculoskeletal:	Swelling in joints	Restricted movement	Pain in muscles
	Pain in joints	Neck problems	Lower back problems
Skin:	Rashes	Lesions	Change in hair or nails
Neurological:	Seizures	Loss of consciousness	Paralysis
	Tremor	Weakness	
Psychiatric:	Depression	Suicide attempts/plans	Anxiety disorder
Endocrine:	Diabetes	Thyroid disorder	
Hematology/ Lymphatic:	Anemia	Abnormal bleeding	Excessive bruising
	Enlarged lymph nodes	Previous blood transfusion	Pitting edema