

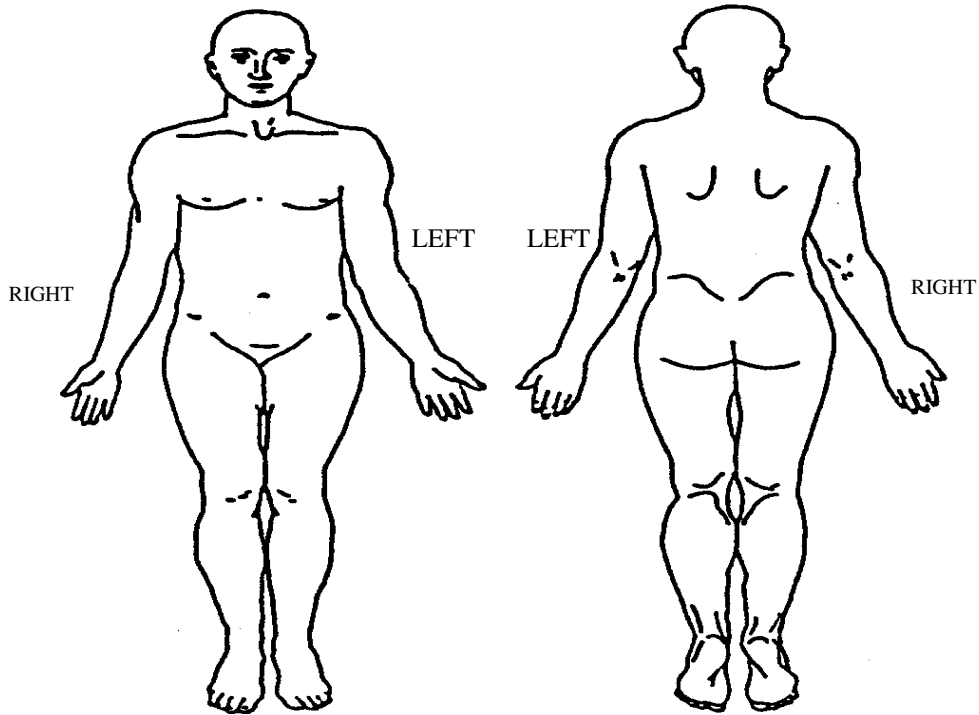
Name _____

Date _____

Valley Pain Specialists: Patient Questionnaire

Please complete **before** your appointment

1. Where is your pain located? Shade in area on diagram.



2. **When** did your pain begin? _____

3. **How** did your pain begin? (injury, workman's compensation, auto accident?)

4. How do you **describe your pain**? (Circle all that apply)

Sharp Stabbing Gnawing Dull Burning Heavy Shooting
Exhausting Throbbing Cramping Sickening Numbing Aching

5. Is your pain constant or on and off? _____

6. What kind of things help relieve your pain? (heat, ice, medicine, sitting...)

7. What kind of things make your pain worse? (stairs, walking...)

8. On a scale of 0-10 circle your average pain over the last month with 10 being the worst:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Worst pain*

9. What treatments have you had for your pain? (Circle all that apply)

Physical therapy Biofeedback TENS therapy Accupuncture
Chiropractic care Medications Counseling Hypnosis
Injections (list type and dates)

Other (list)

10. What tests have you had to evaluate your pain?

Test	Date	Location	Results
MRI			
CT-Scan			
X-Rays			
Myelogram			
EMG			
Other			

11. What **medications** do you take?

12. Do you have **allergies** to medications? No Yes (list) _____

13. Have you ever been exposed to or diagnosed with MRSA? No Yes (date) _____

14. Do you have an Advance Directive? No Yes

15. What **medical problems** do you have?

_____	_____
_____	_____
_____	_____
_____	_____

16. What **surgeries** have you had?

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

17. Do you take blood thinning medications (Example- **Coumadin**)?

No Yes (list) _____

18. Does anyone in your family have a history of spinal problems?

No Yes (list) _____

19. Does anyone in your family have medical problems?

Medical Problems

Father	
Mother	
Brothers	
Sisters	

20. List your present occupation:

21. Are you involved in workers compensation? No Yes (list date of injury)

22. Are you involved in litigation (circle one)? No Yes (name of attorney)

23. Are you (Circle one):

Single Married Widowed Divorced Separated

24. Do you have children? No Yes (number) _____

25. Do you smoke? No Yes (amount) _____

26. Do you drink alcohol? No Yes (amount) _____

27. Do you have any of the following?

	No	Yes	Explain
Chest pains			
Shortness of breath			
Leg swelling			
Depression			
Constipation			
Cancer			
feeding problems			

28. Has there been a change in any of the following?

	No	Yes	Explain
Sleep			
Weight			
Appetite			
Bowel/ Bladder patterns			
Hearing			
Vision			