PATIENT QUESTIONNAIRE (Please print)

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DATE:_____/_____/_____ REFERRING M.D.:_____
NAME:_____ AGE:_____ SEX:_____
HANDEDNESS (right or left):_____ MARITAL STATUS: _____

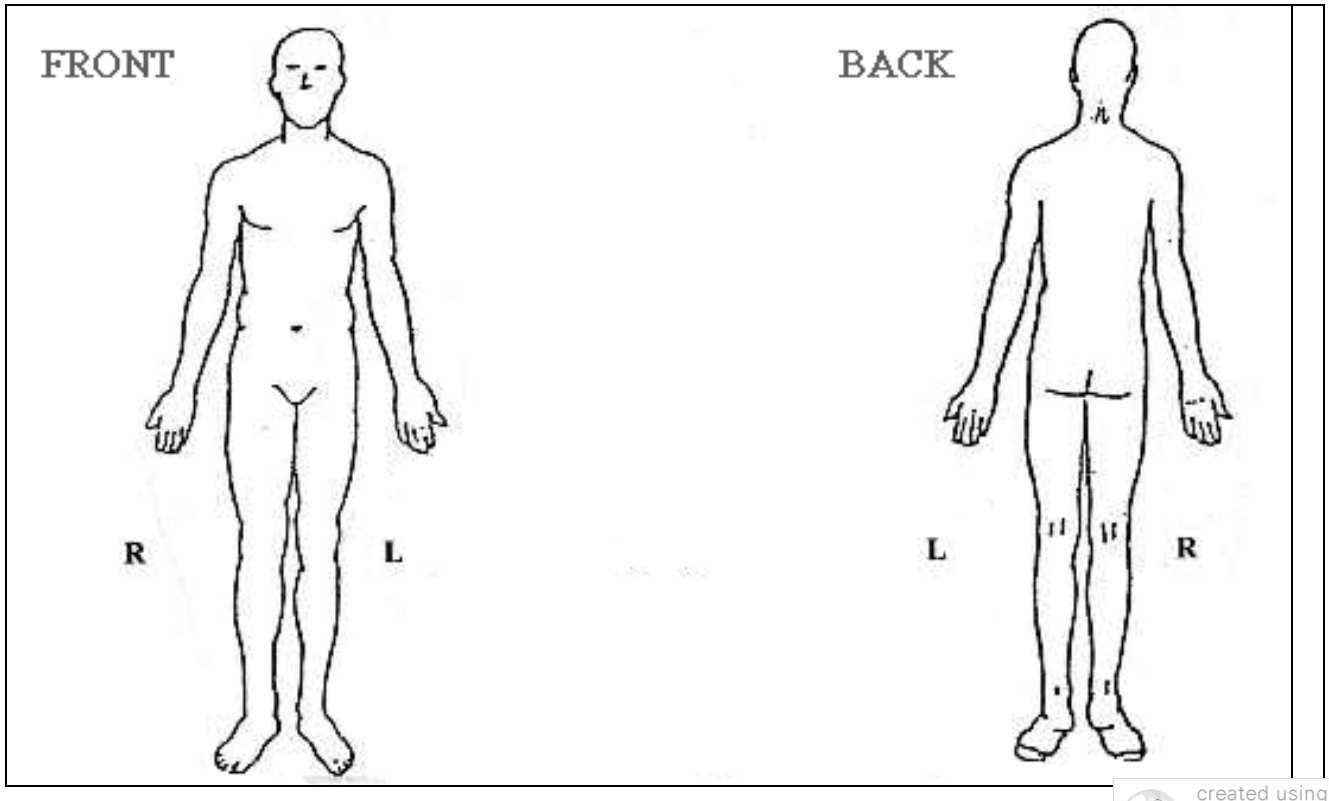
I. Chief Complaint (main problem):
Date of onset of injury:_____. Problem is (circle one): work related / auto accident / neither

Please describe in detail when and how it began, and the duration of time you have had it:

_____
_____
_____
_____
_____
_____

Symptom Drawing
Please mark the area on the figure by using the appropriate symbols to describe the location and the type of symptoms you are experiencing now. Include the affected areas.

Ache XXXXX XXXXX	Stabbing ///////// /////////	Burning ^^^^^^ ^^^^^^	Pins & Needles ++++ ++++	Numbness OOOO OOOO



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Your symptoms are:

Increased by (please circle): N/A standing walking sitting lifting overhead activity cough

Decreased by (please circle): N/A standing walking sitting

How severe are your symptoms: (please circle)

	No Pain				Moderate					Extremely Severe
	0	1	2	3	4	5	6	7	8	9	10
Now	I										I
At its best	I										I
At its worst	I										I

Do you have weakness ? Y N If so, which extremity(ies)? _____

Do you have difficulty with bowel or bladder control ? Y N If yes, explain _____

Do you have increased symptoms at night time ? Y N

List other physicians you have seen for this problem: _____

_____

What treatments (physical therapy, electrical stimulation, tender point injections, epidural injections, facet blocks, chiropractic, bracing, surgery, pain management, acupuncture, psychotherapy, etc.) have you had to date and *when* ?

1. _____
2. _____
3. _____
4. _____
5. _____

List the tests you have had to evaluate your current or related symptoms.

Type of Test: Please list dates(s) / body part(s) studied / facility at which studies were done

Example: X-Ray *8-13-98 Lower back (DMC), 5-6-00 Neck (Memorial), 12-8-00 Pelvis (Gould)*
MRI *6-4-97 Neck (Modesto Imaging), 7-11-99 Shoulder (Memorial)*

X-Ray _____

MRI _____

CT SCAN _____

EMG _____

BONE SCAN _____

OTHER _____

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List *all* medications that you are *currently* taking :

_____

_____

_____

_____

List all other medications and dosages you have taken for pain *in the past* :

_____ _____

_____ _____

List medication allergies : _____

List all current & past medical conditions (blood pressure, diabetes, ulcers, thyroid, kidney problems, cancer, on blood thinner, etc.) :

_____

_____

_____

List prior surgeries (when) : _____

_____

_____

List known family diseases : _____

Current employment / occupation ? _____ and job requirements :
Lifting _____lbs., _____Bending, _____Sitting, ____Standing, _____Pushing, _____Other

Do you or did you smoke ? (If so, # packs/day and # of years of smoking)

_____

Do you or did you drink alcohol ? (If so, # drinks/day and # of years of drinking)

_____

Do you or did you use illicit drugs ? (If so, what kind and how often)

_____

Have you had recent weight loss / gain ? _____(lbs.)

Do you have problem with (circle below): fevers, chills, infections, kidney, heart, lung, stomach, intestine, liver, blood in stool, dizziness, night sweat

Primary care physician ? _____ Your height ? _____ Weight ? _____

End of Questionnaire