

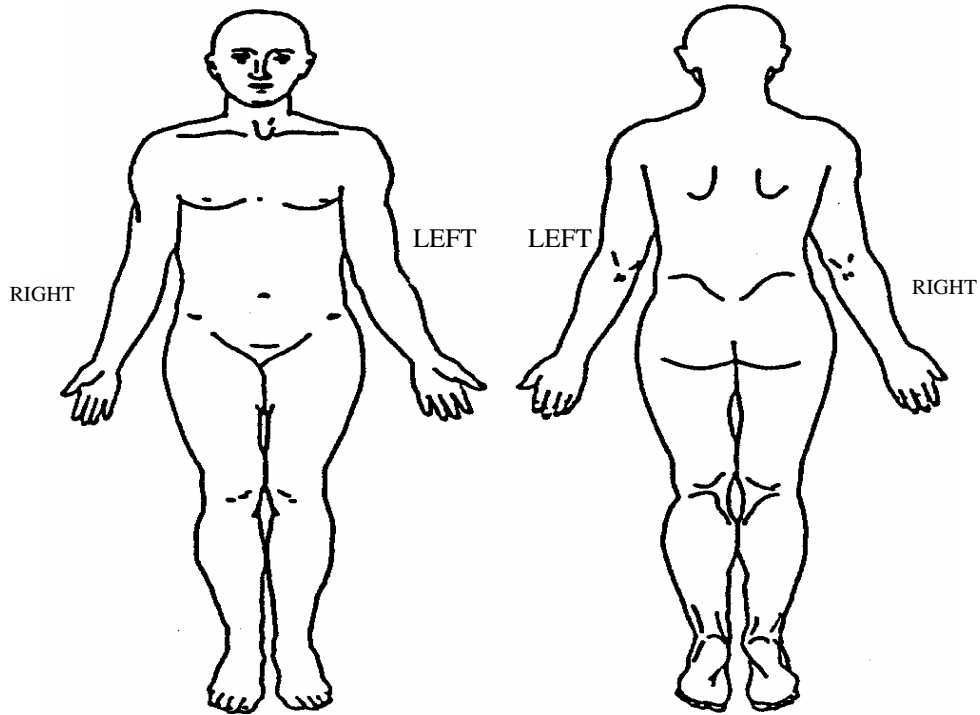
Name _____

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

14. What **surgeries** have you had? Date

15. Do you take blood thinning medications
 (Example- **Coumadin**)? No Yes (list) _____

16. Does anyone in your family have
 a history of spinal problems? No Yes (list) _____

17. Does anyone in your family have
 medical problems?

Medical Problems

Father	
Mother	
Brothers	
Sisters	

18. List your present occupation:

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

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

21. Are you (Circle one):

Single Married Widowed Divorced Separated

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

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

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

25. Do you have any of the following?

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

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

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