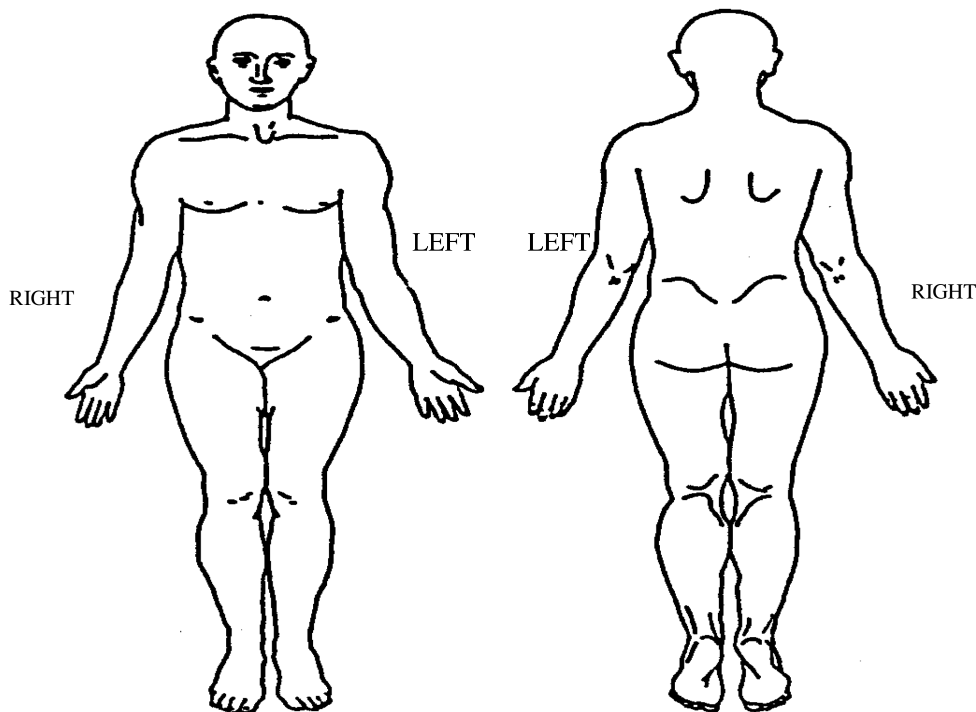
Valley Pain Specialists:
Patient Questionnaire

Name: ___________________________ DOB: ________ Today's date:____________

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



2. **When** did your pain begin? ____
3. **How** did your pain begin? (injury from 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 Numbing Aching Other__________

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

6. What kind of things **help** to relieve your pain? (heat, ice, standing, sitting, etc…)

____

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

____

8. On a scale of 0-10 circle your average pain over the last month with 10 being the worst pain and 0 being no pain.

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

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

Physical therapy Biofeedback TENS Unit Acupuncture Chiropractic care

Medications Counseling Hypnosis Injections (list type and dates)

Any not listed please explain: ____

____

____

What tests have you had to evaluate your pain?

Test	Date	Location	Results/ Do you have the CD?
MRI			
CT-Scan			
X-Rays			
Myelogram			
EMG			
Other			

10. <u>CURRENT Medication List</u>

If you have a list already made with all this info, please hand it in with your paperwork, if there is not enough space to list all your medications please ask the receptionist for an extra sheet of paper. (**List all that apply, including herbal supplements and over the counter medications**)

Medication Name	**Dose (in mg)**	**How many/How Often?**

12. List any allergies and/or intolerances you have: **Check here if none**: _______
<u>What happens when you take it</u>?

____

____

13. Have you ever been exposed to or diagnosed with MRSA? □ YES□ NO
If yes please explain____

14. List all surgeries or procedures you have had done and when:

____

____

____

____

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15. Do you have a history of: (circle all that apply)

Cardiovascular
□ Heart Disease
□ High Blood Pressure
□ Pacemaker/AICD
□ Heart attack(s), year(s) ____
□ Congestive Heart Failure
□ Irregular heartbeat/A-Fib

Hematologic
□ Bleeding Tendency
□ Blood Transfusion(s),
□ Anemia, type: _________

Respiratory
□ Seasonal Allergies
Sleep Apnea
□ Asthma
□ COPD/Emphysema

Gastrointestinal
□ Problems chewing/swallowing
□ Crohns Disease
□ Hiatal Hernia
□ Acid Reflux
□ Irritable Bowel Syndrome

Misc
□ HIV/AIDS (please circle one)
□ High Cholesterol
□ Thyroid Disease
□ Diabetes (Type 1 or Type 2- circle one)
□ Cancer, type ____________________

Urology/Nephrology
□ Renal/Liver Failure
□ Prostate Disease
□ Hepatitis (please circle one: A, B, C)
□ Kidney Stones
□ Incontinence

Psychological
□ Depression
□ Anxiety
□ Bipolar Disorder
□ Dementia/Alzheimer's

Neurological
□ Seizures Do you have Epilepsy? (yes/no)
□ Stroke(s), year(s)________
TIA(s), year(s)__________

If you have any other diagnosed medical problems Please list them here:
____
____
____

16. Do you take any **blood thinners** such as Aspirin, Coumadin, Plavix, Effient, Pradaxa, Lovenox, Aggrenox, Xarelto or NSAIDS? □ YES □ NO
If yes, please list what medication and dose____________________________________

17. Does anyone in your family have a history of spinal problems? □ YES□ NO
If yes, who/what? ____

18. Does anyone in your immediate biological family have medical problems?

	Medical Problems
Father	
Mother	
Brothers	
Sisters	

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19. What is your current occupation:____

20. Are you involved in workers compensation? □ YES□ NO
If yes, what was the date of the injury? _______________________________________

21. Are you involved in litigation? □ YES □ NO
If yes, what is the name of your attorney: ______________________________________

22. Are you (Circle one):
Single Married Widowed Divorced Separated

23. Do you have children? □YES □ NO if yes how many? ______________________

24. **Health Habits** (Indicate frequency in comments) include past and present

	Comments
□ Tobacco	____
□ Alcohol	____
□ Recreational Drugs	____
□ Prescription Drug Abuse	____

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			