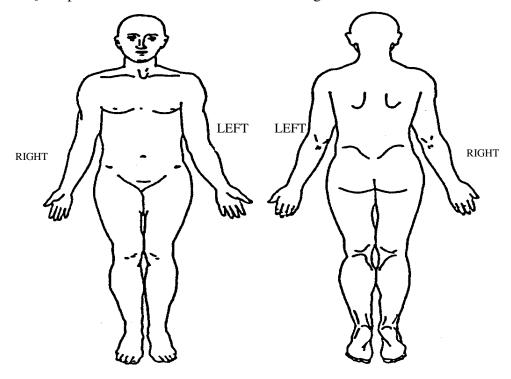
## Valley Pain Specialists: Patient Questionnaire

| 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

## Valley Pain Specialists: Patient Questionnaire

|   |   | • •               | Circle all that | **PP-J/                |     |
|---|---|-------------------|-----------------|------------------------|-----|
| Physical therapy  | y Biofeedback   | TENS Unit         | Acupuncture     | e Chiropractic care    |     |
| Medications   | Counseling  | Hypnosis          | Injections      | (list type and dates)  |     |
| Any not listed p  | olease explain:   |                   |                 |                        |     |
|   |   |                   |                 |                        |     |
| What tests have you   | u had to evaluate<br>Date   | your pain?  Locat | ion Result      | s/ Do you have the CD? |     |
| MRI   |   |                   |                 |                        |     |
| CT-Scan   |   |                   |                 |                        |     |
| X-Rays  |   |                   |                 |                        |     |
| Myelogram   |   |                   |                 |                        |     |
| EMG   |   |                   |                 |                        |     |
| Other   |   |                   |                 |                        |     |
| <b>Medication Name</b>  |   |                   |                 |                        |     |
|   |   | Dose              | (in mg)         | How many/How Often     | 1?  |
|   |   |                   | (in mg)         | How many/How Often     | 1?  |
| 12. List any allergi  | es and/or intolera<br>when you take it'                                 | ances you have    |                 |                        | 11? |
| 12. List any allergi What happens  13. Have you ever                  | es and/or intolera<br>when you take it'<br>been exposed to              | ances you have?   | : Check here    | e if none:             | 1?  |
| 12. List any allergi What happens  13. Have you ever                  | es and/or intolera<br>when you take it'                                 | ances you have?   | : Check here    | e if none:             | 1?  |
| 12. List any allergi What happens  13. Have you ever                  | es and/or intolera<br>when you take it the<br>been exposed to<br>aplain | ances you have?   | : Check here    | e if none:             | 1?  |
| 12. List any allergi What happens  13. Have you ever If yes please ex | es and/or intolera<br>when you take it the<br>been exposed to<br>aplain | ances you have?   | : Check here    | e if none:             | 1?  |
| 12. List any allergi What happens  13. Have you ever If yes please ex | es and/or intolera<br>when you take it the<br>been exposed to<br>aplain | ances you have?   | : Check here    | e if none:             | 1?  |

## Valley Pain Specialists: Patient Questionnaire

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

| Heart Discase  | Cardiovascula   | ır                                   | Misc  |
|--|-----------------|--------------------------------------|---|
| □ Pacemaker/AICD □ Thyroid Disease □ Heart attack(s), year(s) □ Diabetes (Type 1 or Type 2- circle one) □ Congestive Heart Failure □ Cancer, type □ Irregular heartbeat/A-Fib    Hematologic □ Renal/Liver Failure □ Bleeding Tendency □ Prostate Disease □ Blood Transfusion(s), □ Hepatitis (please circle one: A, B, C) □ Anemia, type: □ Kidney Stones □ Incontinence    Respiratory □ Psychological   Sleep Apnea □ Depression □ Asthma □ Arxiety □ Depression □ Asthma □ Depression □ Asthma □ Depression □ Hiatal Hernia □ Scizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ TIA(s), year(s) □ TIA(s), year(s) □ TIA(s), year(s) □ TIA(s), year(s) □ No 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 □ Type Services of the problems?   17. Does anyone in your family have a history of spinal problems? □ YES□ NO   If yes, who/what? □ No your lawe medical problems?   YES□ NO year(s) □ YES□ NO yes, who/what? □ No you have Epilepsy? (yes/no) □ If yes, who/what? □ YES□ NO yes,   | □ Heart Diseas  | ☐ HIV/AIDS (please circle one)       |   |
| □ Heart attack(s), year(s) □ Diabetes (Type 1 or Type 2- circle one) □ Congestive Heart Failure □ Cancer, type □ Irregular heartbeat/A-Fib    Hematologic □ Renal/Liver Failure □ Prostate Discase □ Bleeding Tendency □ Prostate Discase □ Blood Transfusion(s), □ Hepatitis (please circle one: A, B, C) □ Anemia, type: □ □ Kidney Stones □ Incontinence    Respiratory □ Seasonal Allergies   Psychological   □ Steep Apnea □ Depression □ Anxiety □ Dementia/Alzheimer's   □ COPD/Emphysema □ Bipolar Disorder □ Dementia/Alzheimer's   □ Crohns Disease □ Seizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ TIA(s), year(s) □ YES □ NO □ Ti yes, please list what medication and dose □ Ti. Does anyone in your family have a history of spinal problems? □ YES□ NO □ Ti yes, who/what? □ Nedical Problems    Tither   Medical Problems   Tither   Tit  | □ High Blood I  | Pressure                             | ☐ High Cholesterol                              |
| □ Congestive Heart Failure □ Irregular heartbeat/A-Fib   | □ Pacemaker/A   |                                      |   |
| □ Congestive Heart Failure □ Irregular heartbeat/A-Fib   | ☐ Heart attack( | (s), year(s)                         | □ Diabetes (Type 1 or Type 2- circle one)       |
| □ Irregular heartbeat/A-Fib  Hematologic □ Renal/Liver Failure □ Bleeding Tendency □ Prostate Disease □ Blood Transfusion(s), □ Anemia, type: □ □ Kidney Stones □ Incontinence  Respiratory □ Seasonal Allergies □ Sleep Apnea □ Depression □ Asthma □ Anxiety □ COPD/Emphysema □ Bipolar Disorder □ Dementia/Alzheimer's  Gastrointestinal □ Problems chewing/swallowing □ Crohns Disease □ Scizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ Irritable Bowel Syndrome  If you have any other diagnosed medical problems Please list them here: □ 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  Mother  Brothers  | □ Congestive H  | Heart Failure                        |   |
| Hematologic  |                 |                                      | • •   |
| Hematologic  | _               |                                      | Urology/Nephrology                              |
| □ Blood Transfusion(s), □ Hepatitis (please circle one: A, B, C) □ Anemia, type: □ □ Incontinence  Respiratory □ Seasonal Allergies  | Hematologic     |                                      | □ Renal/Liver Failure                           |
| □ Blood Transfusion(s), □ Hepatitis (please circle one: A, B, C) □ Anemia, type: □ □ Incontinence  Respiratory □ Seasonal Allergies  | □ Bleeding Ter  | ndency                               | □ Prostate Disease                              |
| □ Anemia, type: □ Kidney Stones □ Incontinence  Respiratory □ Seasonal Allergies Psychological Sleep Apnea □ Depression □ Asthma □ Anxiety □ COPD/Emphysema □ Bipolar Disorder □ Dementia/Alzheimer's  Gastrointestinal □ Problems chewing/swallowing Neurological □ Crohns Disease □ Seizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ TIA(s), y       |                 |                                      | ☐ Hepatitis (please circle one: A, B, C)        |
| Respiratory  | □ Anemia, typ   | e:                                   |   |
| □ Seasonal Allergies Sleep Apnea □ Depression □ Asthma □ Anxiety □ COPD/Emphysema □ Dementia/Alzheimer's  Gastrointestinal □ Problems chewing/swallowing □ Crohns Disease □ Seizures □ Stroke(s), year(s) □ Irritable Bowel Syndrome  If you have any other diagnosed medical problems Please list them here: □ If you have any other diagnosed medical problems Please list them here: □ If yes, please list what medication and dose □ YES □ NO □ If yes, please list what medication and dose □ Toological □ Stroke(s), year(s) □ TIA(s), year(s) □ TIA(s), year(s) □ YES □ NO □ If yes, please list what medication and dose □ YES □ NO □ If yes, who/what? □ Noes anyone in your family have a history of spinal problems? □ YES□ NO □ If yes, who/what? □ Noes anyone in your immediate biological family have medical problems? ■ Medical Problems  Father  Mother  Brothers  |                 |                                      |   |
| □ Seasonal Allergies Sleep Apnea □ Depression □ Asthma □ Anxiety □ COPD/Emphysema □ Dementia/Alzheimer's  Gastrointestinal □ Problems chewing/swallowing □ Crohns Disease □ Seizures □ Stroke(s), year(s) □ Irritable Bowel Syndrome  If you have any other diagnosed medical problems Please list them here: □ If you have any other diagnosed medical problems Please list them here: □ If yes, please list what medication and dose □ YES □ NO □ If yes, please list what medication and dose □ Toological □ Stroke(s), year(s) □ TIA(s), year(s) □ TIA(s), year(s) □ YES □ NO □ If yes, please list what medication and dose □ YES □ NO □ If yes, who/what? □ Noes anyone in your family have a history of spinal problems? □ YES□ NO □ If yes, who/what? □ Noes anyone in your immediate biological family have medical problems? ■ Medical Problems  Father  Mother  Brothers  | Respiratory     |                                      |   |
| Sleep Apnea  |                 | ergies                               | Psychological                                   |
| □ Asthma □ COPD/Emphysema □ Bipolar Disorder □ Dementia/Alzheimer's  Gastrointestinal □ Problems chewing/swallowing □ Crohns Disease □ Seizures □ Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ Irritable Bowel Syndrome  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   |                 | _                                    | -   |
| □ COPD/Emphysema □ Bipolar Disorder □ Dementia/Alzheimer's  Gastrointestinal □ Problems chewing/swallowing Neurological □ Crohns Disease □ Scizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ TIA(s), y  |                 |                                      | •   |
| Gastrointestinal  Problems chewing/swallowing Crohns Disease Seizures Stroke(s), year(s) Acid Reflux TIA(s), year(s) Irritable Bowel Syndrome  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? If yes, please list what medication and dose  17. Does anyone in your family have a history of spinal problems? If yes, who/what?  18. Does anyone in your immediate biological family have medical problems?  Medical Problems  Father  Mother  Brothers  |                 | ivsema                               |   |
| Gastrointestinal  Problems chewing/swallowing Crohns Disease Seizures Seizures So you have Epilepsy? (yes/no) Stroke(s), year(s) Itiatal Hernia Stroke(s), year(s) Itritable Bowel Syndrome  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? 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   Medica |                 | -5                                   |   |
| □ Problems chewing/swallowing □ Crohns Disease □ Seizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ Irritable Bowel Syndrome  If you have any other diagnosed medical problems Please list them here: □ Stroke (s), year(s) □ Irritable Bowel Syndrome  If you have any other diagnosed medical problems Please list them here: □ Stroke (s), year(s) □ TIA(s), year(s) □  | Gastrointestin  | ıal                                  |   |
| □ Crohns Disease □ Seizures Do you have Epilepsy? (yes/no) □ Hiatal Hernia □ Stroke(s), year(s) □ TIA(s), year(s) □ Irritable Bowel Syndrome  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 □ YES□ NO  If yes, who/what? □ YES□ NO  If yes, who/what? □ YES□ NO  If yes anyone in your immediate biological family have medical problems?  Medical Problems  Father □ Mother  Brothers □ Seizures Do you have Epilepsy? (yes/no) □ Stroke(s), year(s) □ TIA(s), y  |                 |                                      | Neurological                                    |
| □ Hiatal Hernia □ Stroke(s), year(s) □ TIA(s), year(s) □ Irritable Bowel Syndrome  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 □ YES□ NO  If yes, who/what? □ YES□ NO  If yes, who/what? □ Medical problems?  Medical Problems  Father Mother  Brothers  |                 |                                      | _   |
| □ Acid Reflux TIA(s), year(s) □ Irritable Bowel Syndrome  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   Mother   Brothers   Mother   Mother   Brothers   Mother     |                 |                                      |   |
| 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  |                 | •                                    |   |
| 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?   |                 | vel Syndrome                         | 1111(b), year(b)                                |
| 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  | in interest box | er synarome                          |   |
| 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  | If you have an  | y other diagnosed medical pro        | hlems Please list them here                     |
| Lovenox, Aggrenox, Xarelto or NSAIDS?  | II you have un  | y other diagnosed medical pro        | bienis i rease iist them nere.                  |
| Lovenox, Aggrenox, Xarelto or NSAIDS?  | -               |                                      |   |
| Lovenox, Aggrenox, Xarelto or NSAIDS?  |                 |                                      |   |
| Lovenox, Aggrenox, Xarelto or NSAIDS?  |                 |                                      |   |
| Lovenox, Aggrenox, Xarelto or NSAIDS?  | 16. Do you ta   | ake any <b>blood thinners</b> such a | as Aspirin, Coumadin, Plavix, Efficat, Pradaxa. |
| If yes, please list what medication and dose   | =               |                                      | _   |
| 17. Does anyone in your family have a history of spinal problems?   If yes, who/what?  18. Does anyone in your immediate biological family have medical problems?  Medical Problems  Father  Mother  Brothers  |                 | = =                                  |   |
| If yes, who/what?  | If yes, plo     | ease list what medication and        | dose  |
| If yes, who/what?  |                 |                                      |   |
| If yes, who/what?  | 17. Does any    | one in your family have a hist       | ory of spinal problems? □ YES□ NO               |
| 18. Does anyone in your immediate biological family have medical problems?  Medical Problems  Father  Mother  Brothers   |                 |                                      |   |
| Medical Problems Father Mother Brothers  | •               |                                      |   |
| Medical Problems Father Mother Brothers  | 18. Does any    | one in your immediate biolog         | ical family have medical problems?              |
| Father Mother Brothers   | To. Does any    |                                      |   |
| Mother Brothers  | Eathar          | IVICU                                | icai i Tobiciis                                 |
| Brothers   |                 |                                      |   |
|  | Mother          |                                      |   |
|  | Brothers        |                                      |   |
| Sisters  |                 |                                      |   |
|  | Sisters         |                                      |   |

## Valley Pain Specialists: Patient Questionnaire

| 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. <b>Health Habits</b> (Indicate frequency in comments) include past and present Comments      |   |
| - 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   |   |
| Appetite Bowel/ Bladder  |   |
| Appetite   |   |