Medical History Questionnaire

Date ____________________

Name ____ DOB _______________

Reason for visit____

When did symptoms first appear____

Is the condition getting worse? Yes No

Please rate your pain 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Please circle the area of the body that hurts and circle any of the words that describe your discomfort.

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness

Left

Left

How often do you have this pain?

Constantly (76-100% of the day) Frequently (51-75% of the day)
Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Does it interfere with work sleep daily activities recreation

What activities aggravate your condition? (Check all that apply)

Standing Sitting Walking Bending Tension Lack of Sleep Lying Down Lifting

Driving Reaching Over Head Sexual Activity Working on the Computer Rainy Weather

What makes your pain better? (Check all that apply)

Lying down Walking Sitting Standing Medication Sleep Heat Ice Massage

Exercise Stretching Traction TENS Corset Biofeedback Compression

Do you experience the following symptoms? (Check all that apply)

Headaches Dizziness Memory Loss Concentration Deficits Nausea

Vomiting Balance Disturbances Weakness Numbness Bowel Dysfunction

Bladder Dysfunction Fatigue Irritability Difficulty Walking Depression

Anxiety Weight Gain/Loss Swelling Color Changes Hair Loss Coldness Warmth

Do you or have you ever suffered from the following medical conditions?

Headaches
Neck Pain
Upper Back Pain
Mid Back Pain
Low Back Pain
Should Pain
Elbow/Upper Arm Pain
Wrist Pain
Hand Pain
Hip/Upper Leg Pain
Ankle/Foot Pain
Jaw Pain
Joint Swelling/Stiffness
Arthritis
Rheumatoid Arthritis

High Blood Pressure
Heart Attack
Chest Pains
Stroke
Liver Disease
Kidney Stones
Kidney Disorders
Bladder Infections
Painful Urination
Bowel/Bladder Dysfunction
Prostate Problems
Weight Gain/Loss
Loss of Appetite
Abdominal Pain
Ulcer

Diabetes
Excessive Thirst
Frequent Urination
Allergies
Depression
Systemic Lupus
Epilepsy
HIV/AIDS

General Fatigue
Muscular Incoordination
Visual Disturbances
Dizziness
Hepatitis
Gall Bladder Problems
Cancer
Tumor

Indicate if you have a family history of any of the following:

Rheumatoid Arthritis   Multiple Sclerosis   Diabetes   Cancer

Lupus   Heart Disease   High Blood Pressure   Stroke

What is your height and weight?   Height   Weight   lbs
Ft   inches

List all prescription and over-the-counter medication you are taking or attach list if you have one.

List all surgical procedures you have had and the times you have been hospitalized:

List all medication allergies or intolerances:

Have you ever smoked?   Yes   No   Presently

Do you drink?   Alcohol   Coffee   Tea   Sodas

Do you use recreational drugs?   Yes   No

Are You: Single   Married   Separated   Divorced   Widowed

Do you have children?   Yes   No   How old are they? ___________________________________

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU WERE INJURED ON THE JOB OR INVOLVED IN AN ACCIDENT!!!

Is this a work related injury or illness?   Yes   No

Is this an accidental injury?   Yes   No   Car Accident   Fall   Other: ____________

Date of injury: _________________   When did you first notice pain? _______________

Are you currently working?   Yes   No   Full Duty   Light Duty_

Sitting ______hrs   Standing ______hrs   Lifting ________hrs

Bending_______hrs   Computer ________hrs

Climbing yes no   Climbing yes no   Repetitive Motion yes no

If yes, then how many hours each day? ______________________________

What are your job responsibilities? ____

____

Is your supervisor sympathetic to your needs? Yes No

If you are not working, how long have you been out of work? _____________________________

Have you tired to return to work? Yes No

Why did you stop? ____

Does your Employer offer Modified Duty? Yes No

Please list your work history (include how long you worked at your job before this injury occurred)

____

____

If you were injured in a car, please check the appropriate descriptive:

You were the: driver   passenger in the: front rear___

Rear end collision broadsided sideswiped

Was your seat belt on? Yes No_____

Have you ever had a similar problem with pain? Yes No

Please describe: ____

Have you reported this accident to your Auto Insurance? Yes No

Is there a Lawyer involved in your case? Yes No

Name of Lawyer: ____

Phone Number: ____

Describe what happened (mechanism of injury): ____

____

Was the onset of your pain? sudden gradual

Did you go to the Emergency Room? Yes No When/Where? ____________________

Check all diagnostic tests that were performed:

Plain x-rays

CAT scan

MRI
EMG/Nerve Conduction Studies
Myelogram/Discogram

What treatment did you receive? ____

____

How many hours per day do you have pain? (If you do not have pain every day, estimate how many hours of pain per week, month, etc.) ____

How many weeks, months or years have you been disabled by pain? ______________

Do you occasionally need to stop all activities because of pain? Yes No

If yes, number of times: __________ daily __________ weekly

What activities are most affected by your pain? ______________________________

Please describe your usual daily routine: ______________________________________

____

Describe your regular exercise routine and frequency: _____________________________

____

Do you have severe nighttime pain? Yes No

Do you wake up in the middle of the night because of pain? Yes No

If yes, then how many times? ______________________________

Do you have difficulty falling asleep at night? Yes No

Do you wake up unusually early in the mornings? Yes No

Previous Treatment (check all that apply)

	Lasting		Temporary Relief	
Physical Therapy Modalities (ultrasound, hot packs, traction, electrical stimulation, soft tissue release, therapeutic exercise)	yes	no	yes	no
Assistive Devices (wheelchair, walker, crutches, cane)	yes	no	yes	no
TENS	yes	no	yes	no
Biofeedback	yes	no	yes	no
Mobilizations/manipulations	yes	no	yes	no
Psychological support	yes	no	yes	no

Brace, splint, cervical collar yes no
yes no
Back school education yes no
yes no
Work hardening yes
no yes no
Injections (trigger point, facet block,
nerve block, epidural, joint injection) yes no
yes no
Acupuncture yes
no yes no
Implants yes
no yes no

Pain Clinic yes no Where? ___________________________When?
____

If you have seen or are currently seeing a Psychologist or Psychiatrist please list their name?

____

______________________________ ________________
Signature of Patient Date