Pain Questionnaire

Your name _____How old are you? _____ Date _____

Your primary doctor _____Telephone _____

Your referral doctor _____ Telephone _____

How do you know us? Your Doctor ( ); Friend( ); Newspaper( ); Radio/TV( ); Other ( )

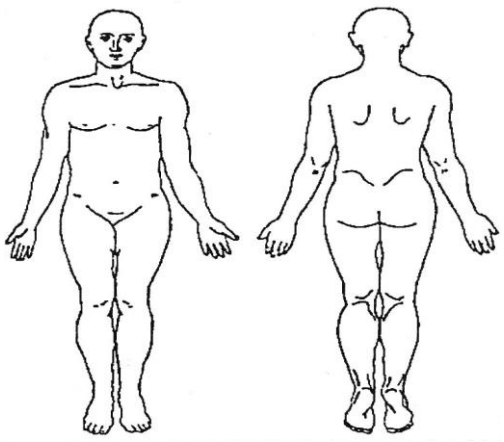
When did your pain first begin? _____

Were there any particular events that started your pain? _____

What is the Quality of Your Pain?

❑Sharp ❑Dull ❑Electrical
❑Burning ❑Numbness ❑Pins and needles
❑Shooting ❑Hot ❑Cold

Please mark on your Pain



How Strong is Your Pain?
1.Mild **2**.Discomforting **3**.Distressing
4.Horrible **5**.Excruciating

The Impact of Your Pain

❑Sleep ❑Daily activates ❑Standing and Walking

Past Pain Treatment: Check if you visited:→

❑Acupuncturist ❑Anesthesiologist
❑Chiropractor ❑Internist
❑Neurologist ❑Orthopedist
❑Physical Therapist ❑Psychiatrist
❑Other

Pain Medications:_____

Past Medical History :

❑High Blood Pressure ❑Migraine Headaches
❑Angina/Chest Pain ❑Seizures
❑Asthma ❑Hepatitis/Jaundice
❑Smoking ❑Alcoholism
❑Stomach Ulcers ❑HIV
❑Kidney Failure ❑Cancer – any type

Any **Allergy: No( ); Yes( )**

❑Diabetes
❑Other illness

Current Medications (include blood thinners) _____
Past Surgeries History :_____
Social History(check if yes)
Married( ); Employed( ); Disability( ); Live with family( )Alcohol( ); Smoking( ); Lawsuit( ) _____

Please sign your name verifying that the above medical history is correct.

Signature _____ Date _____