

# PATIENT HISTORY QUESTIONNAIRE

1. When (roughly what date) did your present pain start? \_\_\_\_\_
2. Area Involved (please check)
  - Right     Left     Shoulder
  - Foot     Ankle     Neck
  - Hand     Wrist     Back
  - Knee     Elbow     Hip
  - Other \_\_\_\_\_
3. Symptoms
  - Pain     Swelling     Stiffness
  - Instability     Tingling     Numbness
  - Locking     Catching     Giving way
4. Does your pain radiate or move to another body part?
  - Yes, where? \_\_\_\_\_
  - No \_\_\_\_\_
5. Which statement best describes your level of pain/symptoms? (please check one)
  - Just wanted to make sure its nothing serious
  - Aggravating, but I can live with it
  - Interferes only with strenuous activity
  - Moderate
  - Severe
  - Disabling
  - Other \_\_\_\_\_
6. How did the pain start? (please check all appropriate boxes)
  - Suddenly     Pulling
  - Gradually     Injured at work
  - Lifting     Injured in auto accident
  - Twisting     Hit from behind
  - Falling     Injured during sports
  - Bending     No apparent cause
7. What activities make pain/symptoms worse?
  - Standing     Twisting
  - Walking     Bending
  - Running     Kneeling
  - Exercise (during)     Squatting
  - Exercise (after)     Stairs
  - Lifting     Coughing
  - Lying in bed     Sneezing
  - Other \_\_\_\_\_
8. What reduces the pain/symptoms?
  - Lying down     Pain pills
  - Sitting     Muscle relaxant pills
  - Walking     Aspirin or  
anti-inflammatory pills
  - Physical therapy     Other \_\_\_\_\_
  - Nothing \_\_\_\_\_
9. What other doctors or healthcare providers have you seen for this condition?
 

Name	Specialty	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
10. Have you had any of these diagnostic studies?
 

	Yes	No	Date
X-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT (computed tomography scan)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI (magnetic resonance imaging)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthrogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electromyogram (EMG)	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Have you been hospitalized for your pain problem?
  - Yes, number of times \_\_\_\_\_  
Dates \_\_\_\_\_
  - No
12. Have you had surgery for this problem?
  - Yes, number of times \_\_\_\_\_  
Dates \_\_\_\_\_
  - No
13. Are you still working?
  - Yes
  - No    Last day on job \_\_\_\_\_
14. Do you plan to be at your regular job in 6 months?
  - Yes     No
15. Do you like your job?
  - Yes     No
16. Are you under stress at home or work?
  - Yes     No
17. Please indicate last grade completed in school  
\_\_\_\_\_
18. To be sure paperwork is filled out correctly, please check if appropriate:
  - On Workers' Compensation
  - Receiving disability income
  - Legal proceeding pending
  - Report should be sent to:  
\_\_\_\_\_  
\_\_\_\_\_
19. Do you have any additional information that would be helpful in understanding your problem?  
\_\_\_\_\_  
\_\_\_\_\_