Patient Questionnaire

Name: _____ Date: _____ Age: _____

Referral Source: _____ Diagnosis: _____

Occupation: _____ Employer: _____

Date of Injury: _____ Are you working now?: Y N If no, last day worked: _____

Patient Presentation

How did you injure yourself? _____

Where is your pain? _____

Is your pain: Constant 75-100% Frequent 50-75% Occasional 25-50% Intermittent 0-25%

A.M. (upon waking are you) Stiff/Sore Are you at your Best/Worst

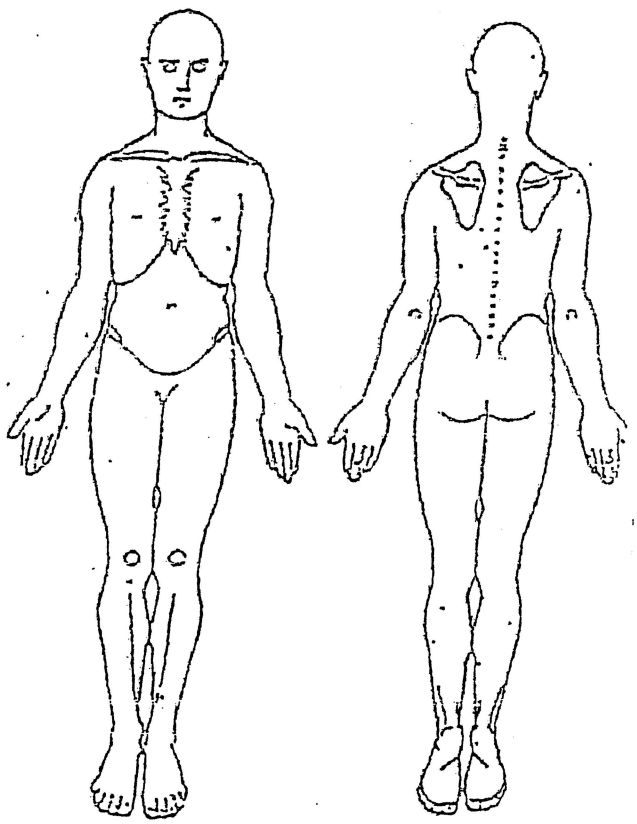
Progression through day: _____

Do you have any sleep disturbances: _____

Comments: _____

_____

Please mark where your pain is located



Pain Intensity: (0 = no pain, 10 = emergency room)

Now: Best: Worst:

What activities increase pain: _____

_____

What activities decrease pain: _____

_____

Do you have any headaches: ___ If so, how often: _____

Do you have any episodes of dizziness, visual disturbances, ringing in ears or Nausea: yes no

Comments: _____

Do you have any past medical problems or surgeries?

Yes: No: Comments: _____

_____

Current medications: _____

Steroids: Yes/No Current Past If yes, date(s) _____

Epidurals: Yes/No If yes, date(s) _____

Radiological Studies: X-Ray MRI CT-Scan Name of Facility: _____