0219

Global Institute of Spine and Joint Care

Today's Date_____

Patient's Name_____DOB_____

Street Address_____ Apt. No._____

City / State / Zip Code_____

Home Phone#_____ Work/Cell Phone#_____

☐ Leave message on Voice Mail

Social Security # _____ DL#_____ State_____

Sex: _Female _Male Marital Status: _Single _ Married _Divorced Widowed

Spouse's Name _____ Spouse's Telephone#_____

Your Employer_____

Employer's Address_____

City / State / Zip Code_____

Employer's Phone#_____ Position_____

Emergency Contact_____ Relationship_____

Home Phone#_____ Work Phone#_____

Primary Care Physician _____ Office Phone#_____

Referred By _____ Office Phone#_____

Reason for Appointment_____

Global Institute of Spine and Joint Care

PAIN PATIENT QUESTIONNAIRE

1. What is the main complaint for which you are seeking treatment?

_____

_____

_____

2. How long have you had the pain problem you are currently experiencing?

_____

3. How did your current pain start?

_____

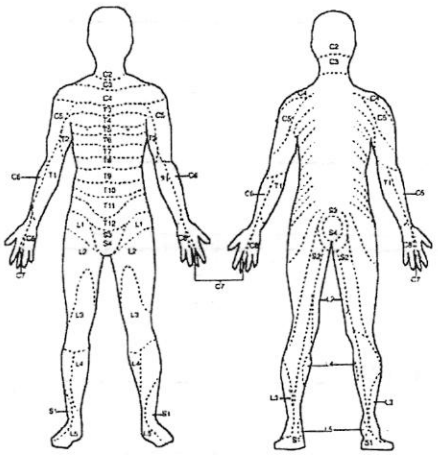
_____

4. Have any other Health Care Professionals and/or Specialist been involved in the evaluation and treatment of your current pain? (Please specify)

_____

_____

Please mark the areas of your pain in the diagram below:



5. Please list all medications you have tried for your **current pain problem.**

_____

_____

_____

6. Please check all of the treatments you have tried for your pain from the list below, and complete the appropriate columns at the right.

TREATMENT	DATES	RESULTS
__Hospital Bed Rest	_____	_____
__Traction	_____	_____
__Surgery	_____	_____
__Acupuncture	_____	_____
__TENS(Electrical Stimulator)	_____	_____
__Physical Therapy	_____	_____
__Chiropractor	_____	_____
__Epidural, Nerve Block, Neuroforamen Inj	_____	_____
__Exercise: Structured Program, Yoga, Tai Chi, Self Gym, Pilates, walking		_____
__Other- Specify or circle: Therapeutic massage, aquatic therapy, etc.		_____

7. How often do you have pain? _____

8. Check any symptoms and adjectives associated with your pain:

__Numbness	__Weakness	__Urinary Incontinence
__Redness	__Swelling	__Tenderness of affected area
__Cool, Pale skin	__Burning	__Pain with only a light touch
__Mild	__Shooting	__Prevents family duties
__Moderate	__Stabbing	__Prevents social duties
__Strong	__Tingling	__Affects appetite
__Dull	__Cramping	__Throbbing
__Aching	__Squeezing	__Sexual Dysfunction

9. Does your pain affect your sleep? (Circle) Yes No Falling asleep? Yes No

10. Are there any factors that make your pain:
Better? (Please List) _____
Worse? (Please List) _____

11. During the past month, is your pain worse in the (circle all that applies) :
___ Morning ___Afternoon ___Evening ___Night ___No typical pattern

12. Have you ever had psychiatric or psychological evaluation or treatment for the problems including your current pain? (circle) Yes No

13. Have you had any radiology done(MRI's , Xrays, etc) in the last 24 months for your current pain problem
Yes/No: Locations_____
14. Do you have any drug allergies? (Please List) _____
_____

15. Are you allergic to seafood? (Circle) Yes No 16. Allergic to Latex? Yes No