Patient Name: _____ Date: _____

Date of Birth: _____

Age: _____ Weight: _____ Height: _____

Pain Patient Questionnaire

CHIEF COMPLAINT:

Please list your pain site in order of importance (rank the worst problem as "a:, the next as "b", etc.)

A. _____

B. _____

C. _____

HISTORY OF PRESENT ILLNESS:

Date when your pain began? _____ Did this pain begin: (Circle one) gradually OR suddenly

How did this pain begin? (Circle one) Accident: at work at home auto OR

Following an Illness OR Following Surgery

Explain: _____

Is this pain the same now as it was when it began? (Circle one) Same Better Worse

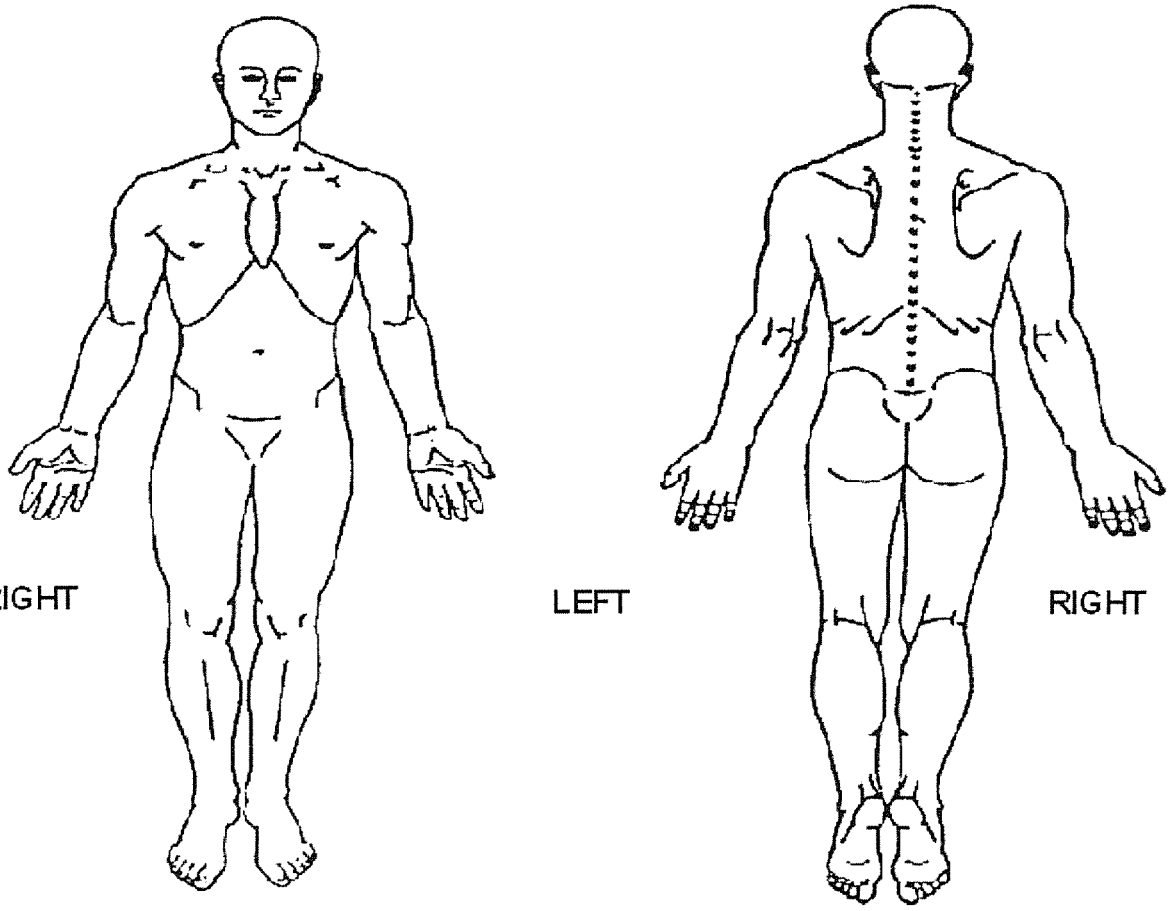
Is there a time of day that your pain is worse? (Circle one) Morning Noon Afternoon Evening Wakes you at night

Please indicate which diagnostic procedures (tests) you have had for this pain problem:

X-Ray Date and Facility: _____
CT Scan Date and Facility: _____
MRI Date and Facility: _____
Discogram Date and Facility: _____
Myelogram Date and Facility: _____
EMG Date and Facility: _____
Bone Scan Date and Facility: _____
Done Minderal Density (BMD) (Test for Osteoporosis) Date and Facility: _____
Vertebral Fracture Assessment (VFA) Date and Facility: _____

Patient Name: _____

Date of Birth: _____



Use this legend to draw your pain on the body diagram above

°°°°°°°° **Pins and Needles**

/ / / / / / / / / / **Spasm: Tension Type**

Dull Aching Pain

******** **Excruciating**

••••••**Burning, sharp, shooting**

= = = = = = **Numbness**

X X X X X X **Unbearable**

☐ ☐ ☐ ☐ ☐ ☐ **Other:** _____