



Initial Visit Questionnaire

Please circle the appropriate answers

Date: _____

Name: _____ Age: _____ Sex: M / F

Chief Complaint: _____ Marital Status: S / M / D / W

Referring Physician: _____

Source of referral: Advertisement Yellow pages Internet Friend other

Please circle area of pain? Head Neck Rt. Shoulder Lt. Shoulder Rt. Arm

Lt. Arm Mid Back Low Back Hip Rt. Knee Lt. Knee

Rt. Foot Lt. Foot Other _____

On the body chart, please shade area of pain:

Right

Left

Left

Right



Front



Back

Is Pain (Circle One): Constant / Intermittent

How long have you had pain (Circle One): Days _____ Weeks _____ Months _____ Years _____



Did your pain begin with a **specific event**: **Y / N**

If yes describe briefly: _____

What makes your pain better? Medication PT Rest Other _____

What makes your pain worse? Standing Walking Working Overhead Activities

Other _____

On a scale of 1-10, with 10 being extreme pain and 0 being no pain please rate your pain: (Circle

One) 0 1 2 3 4 5 6 7 8 9 10

Do any of these words describe your pain? (Circle One)

Burning – Splitting – Cramping - Shooting – Dull – Crushing – Sore – Throbbing

Stabbing – Numb – Pins and Needles- Other _____

Has the pain changed in the last 4 weeks? **Y/ N**

Which **medications** are you taking **for pain**? Doses if known

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____



What other medications are you taking (Doses not important)

How long have you been taking these medications? _____

By what percent do your medications diminish your pain? _____ %

Are there any other side effects from your pain medications? Y / N

What Side effects? _____

Are you taking your pain medications as prescribed? Y / N

Are you on a **blood thinner**? Y / N

Test	Area Scanned	Date	Results
Xray			
CT Scan			
MRI			
Bone Scan			
EMG			
Mylogram			
Other Test			

Please list any interventions you have had for this problem (Circle One)

Chiropractic – Shots – Biofeedback – Massage – Tens (Electrical Stimulation)

Physical therapy – Epidural injections – Acupuncture – other injections



Have you seen any other doctors for this pain Y / N (Circle One)

Neurosurgeon

Orthopedic

Pain doctor

Psychiatrist

Has your pain caused you to miss days from work? Y / N

Are you currently working Y / N

Are you disabled? Y / N

Are you currently involved in any lawsuit? Y / N

Please circle any previous illnesses: (circle one)

Diabetes – pacemaker/Heart Condition – High Blood pressure – Blood Disorder

Thyroid Problems – Cancer – Stroke – Steroid/Cortisone Therapy – Skin Disease

Migraine Headaches – Seizure/Epilepsy – Problems with eyes – Ear/Nose/Throat

Problems – Other (Please Explain) _____

Please list all of your surgeries and year they were performed

Please list any medication allergies and your reaction to them if taken:



Have you ever been treated for a psychiatric or psychological disorder? Y / N

Family History	Parent(s)	Grandparents	Sibling(s)
High Blood Pressure			
Stroke			
Heart disease			
Arthritis			
Diabetes			
Cancer			
Glaucoma			

Social History

List all the people who live with you

Do you smoke? Y / N
How many packs per day? _____

Do you drink Alcohol? Y / N
How Much per Week? _____

Do you use recreational drugs? Y / N If yes what kind: _____

Do you exercise regularly? Y / N

Please list your **hobbies**.

What is your highest level of education?

What is your occupation?



How many children do you have? _____

Do you live in an **apartment**, a **house**, or **condo**? (Circle One)

Do you need the help of another person to?

Get into and out of bed?	Y / N
Go to the Bathroom?	Y / N
Bathe or shower?	Y / N
Get into or out of chairs?	Y / N
Walk?	Y / N

Do you use a **Cane or a Walker**? (Circle One)

Do you have any **Fever**? Y / N

Do you have any **Weakness**? Y / N

Do you have any changes to **bowel or bladder function**? Y / N

Do you have any **numbness**? Y / N

Do you have any recent **weight loss**? Y / N

Do you have **Constipation**? Y / N

Do you have **Depression**? Y / N

Have you ever been **Sexually Abused**? Y / N