

The Rose Center for Rehabilitation, Hope, and Wellness

PATIENT HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Occupation: _____

1. Where is your pain/problem: _____

2. Date of onset of the pain / surgery / injury (circle one): _____

3. Briefly describe how / why your pain started: _____

4. The pain is currently getting (circle one): Better Worse Same Activity dependent

5. Pain Level: _____ Scale 0=no pain----moderate pain----10=severe pain - going to E.R.

6. Stress Level: _____ Scale 0=no stress----moderate stress----10=sever stress

7. Action or positions that make the pain worse:

Back / Neck / Spine

- forward bending
- backward bending
- sitting _____ min.
- standing _____ min.
- exercise during/after
- other: _____

- coughing
- sneezing
- walking
- lying down
- wakes me at night

Knee / Hip

- up/down stairs
- kneeling
- walking / running
- bending knee / hip
- exercise during/after
- other: _____

- straightening
- sitting _____ min.
- standing _____ min.
- lying down
- wakes me at night

Shoulder

- reaching up
- hand behind my back
- reaching across my chest
- doing my hair
- wakes me at night
- other: _____

8. Actions or positions that make you better: _____

9. Is your pain : better in the morning better at the end of the day activity dependent
 worse in the morning worse at the end of the day

10. Additional comments that might be helpful in your treatment: _____

HEALTH INFORMATION

11. Past Medical History:

- cancer
- arthritis/RA
- diabetes
- pregnant
- bowel or bladder problem
- heart _____
- pacemaker/metal implant
- epilepsy

13. Diagnostic studies:

- | | | | |
|-------------------|------------------------------|-----------------------------|------|
| Diagnostic x-rays | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date |
| CT scan | <input type="checkbox"/> | <input type="checkbox"/> | |
| Myelogram | <input type="checkbox"/> | <input type="checkbox"/> | |
| EMG | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discogram | <input type="checkbox"/> | <input type="checkbox"/> | |
| MRI | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthrogram | <input type="checkbox"/> | <input type="checkbox"/> | |
| Injections | <input type="checkbox"/> | <input type="checkbox"/> | |

12. Medication: please list or provide a list: _____

14. Allergies: _____

15. Have you been hospitalized for this problem?

Yes No Date: _____

 Why? _____

16. What other healthcare providers have you seen for this condition? _____

=====

TODAY

17. Where is your pain today: _____

18. Pain level: _____ Scale 0=no pain----moderate pain----10=severe pain - going to E.R.

19. Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

20. Mark the areas where the pain spreads.

Aching
^^^^^

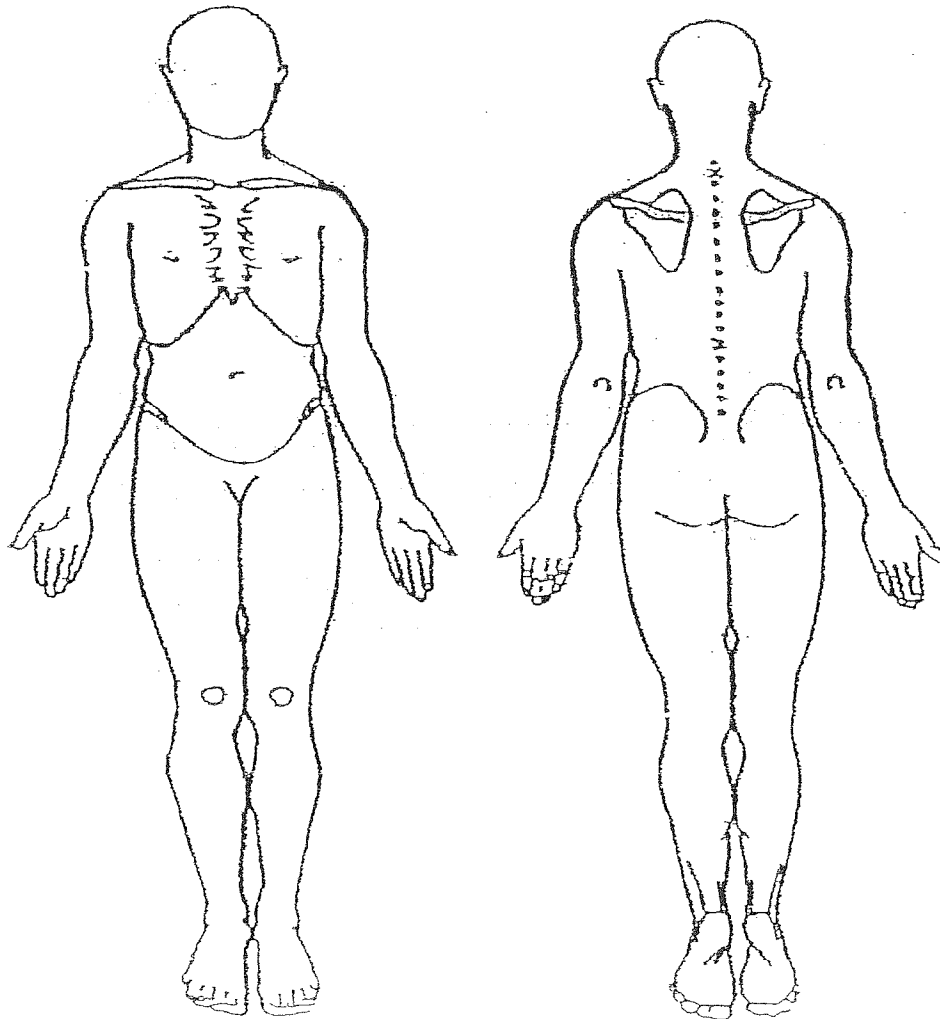
Numbness
>>>>>

Pins and Needles
OOOOO

Burning
XXXXX

Stabbing
/////

"Sore"
✓✓✓✓



Reviewed by: _____