

INITIAL PATIENT QUESTIONNAIRE FORM

IT IS IMPORTANT TO FILL THIS FORM OUT COMPLETELY

Name: _____ Date: _____ Age: _____

1. Sex: Male Female Right Handed Left Handed Occupation _____

2. Chief Complaint (Where is your pain?): _____

3. Onset Date (date of injury): _____

4. Type of injury / condition: Gradual Onset Work Comp. Auto Surgery Sports Other

5. Specifically describe your injury / condition: _____

6. Surgery Date: _____ Type of surgery: _____

7. Diagnostic testing related to this injury / condition:

X-Ray results: _____ MRI results: _____

8. Treatment related to your injury / condition: _____

9. Rate Your Pain: Currently _____ Best: _____ Worst: _____ (Pain: 0–10) 0=No Pain 10=Worst Pain)

10. What makes your pain worse? 1. _____ 2. _____

3. _____ 4. _____

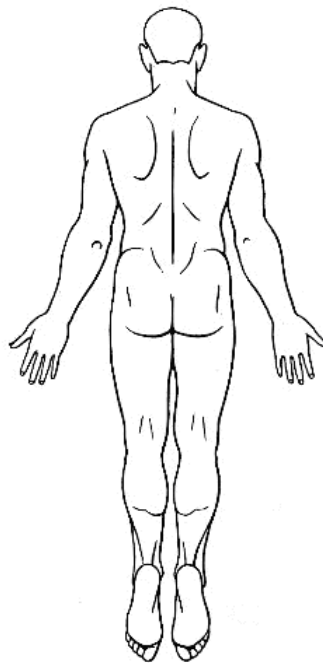
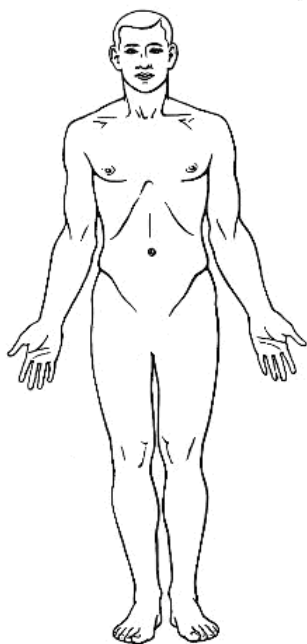
11. What lessens your pain? _____

12. Have you experienced similar problems in the past: Yes No

13. What Activities are you having difficulty with as a result of your injury / condition?

1. _____ 2. _____

3. _____ 4. _____



Where is the pain?

Pain Drawing:

Place symbols of your pain description on the body diagram on the left. This is to help us understand more about your symptoms. Please create your own symbols to describe your pain.

| Pain Symbol | Description |
|-------------|-------------|
| X | Sharp |
| O | Numbness |
| A | Achy |
| S | Stiffness |