



## GENERAL PATIENT QUESTIONNAIRE

*Thank you in advance for taking the time to complete this form, as this will help us to better assess all of your pain concerns and provide you with the best treatment.*

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Age: \_\_\_\_\_

### Accident Details:

1. Please describe your injury:

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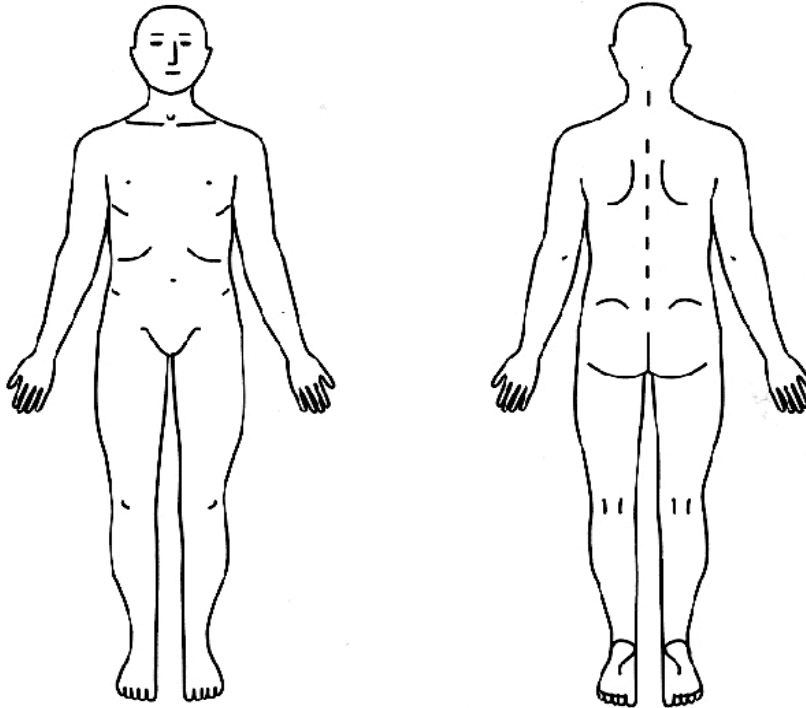
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Please take a moment to specifically identify your pain:

**B2. Pain drawing**

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	—	INC Sensitivity	0000
Constant Throbbing Ache	xxx	Sharp Twinge	////



What is your pain level at rest? (circle):

**NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE**

What is your pain level with activity? (circle):

**NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE**

How would you describe your pain? (circle):

- |               |                |          |
|---------------|----------------|----------|
| Deep-pressure | Tightness      | Spasms   |
| Tingling      | Numbness       | Pinprick |
| Burning       | Sharp-shooting | Stabbing |



Have you **EVER** had any other type of injury?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**MEDICAL CONDITIONS** (Please list: such as diabetes, depression, gastric reflux):

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**MEDICATIONS** (Including any Tylenol, ibuprofen, Motrin):

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**SURGERIES:**

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**ALLERGIES:** \_\_\_\_\_

**FAMILY HISTORY:**

FATHER – age \_\_\_\_, alive ( circle): Yes / No

- medical conditions: \_\_\_\_\_

MOTHER – age \_\_\_\_, alive (circle): Yes / No

- medical conditions: \_\_\_\_\_

**SOCIAL HISTORY:**

Tobacco use (circle): Yes / No

Alcohol use (circle): Yes / Social / No

Drug use (circle): Yes / No

**REVIEW OF SYSTEMS:** *(mark only if positive)*

**General-**

Weight loss or gain

Fatigue

**Skin-**

Rashes

Dryness

**Head-**

Headache

Head injury

**Ears-**

Decreased hearing

Ringing in ears

Fever or chills

Lumps

Earache

**Eyes-**

- Glasses or contacts
- Blurry or double vision
- Flashing lights

**Nose-**

- Discharge
- Itching
- Nosebleeds

**Neck-**

- Lumps
- Swollen glands

**Cardiovascular-**

- Chest pain
- Tightness
- Palpitations

**Respiratory-**

- Coughing up blood
- Shortness of breath
- Painful breathing

**Gastrointestinal-**

- Constipation / Diarrhea
- Change in appetite
- Nausea

**Urinary-**

- Increased Frequency
- Incontinence
- Blood in urine

**Musculoskeletal-**

- Muscle or joint pain
- Redness of joints
- Swelling of joints

**Neurologic-**

- Dizziness
- Fainting
- Seizures

**Psychiatric-**

- Nervousness
- Depression
- Memory loss

*Thank you!*

*Office use:* \_\_\_\_\_