Patient Questionnaire

Patient name: _____ PHN: _____

Date: _____ Date of birth: _____

Answering these questions will help your doctor with today's visit.

1. What is the #1 problem you are seeing your doctor for today:

   _____

   _____

   Is this problem the result of a:
   - ☐ Work-place injury (Date of injury:)
   - ☐ Car accident (Date of injury:)
   - ☐ Accident, including falls (Date of injury:)

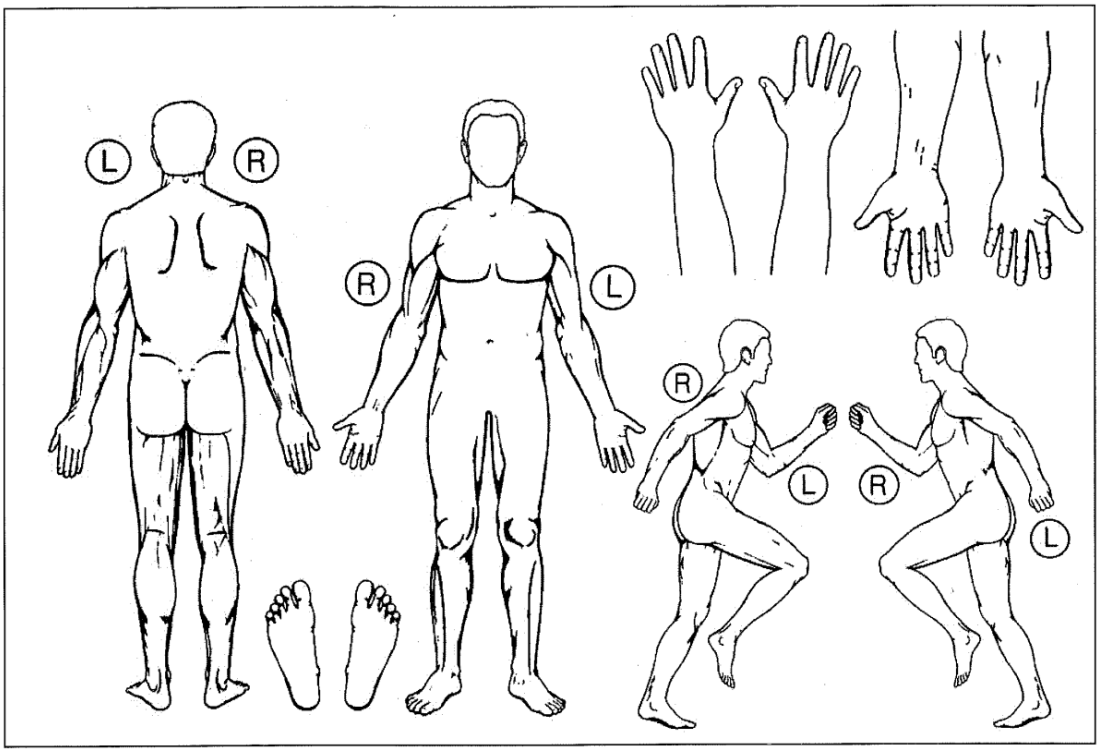
2. Please describe the symptoms you are having:

   _____

3. Have you experienced any of the following in the last 1 to 4 weeks?

   - ☐ Fever
   - ☐ Weight loss
   - ☐ Night sweats
   - ☐ Night pain that wakes you up
   - ☐ Fatigue
   - ☐ Bowel or bladder problems
   - ☐ Tingling / numbness
   - ☐ Other (please describe below)

4. On the following picture, mark the area where you are having these symptoms:



Please turn over the page

5. How long have you had these symptoms? Please write the number of days, weeks, months, or years: Days ___ Weeks ___ Months ___ Years ___

6. How did your symptoms start: _____

_____

7. Are any of your joints swollen? ☐ Yes ☐ No

8. Are your joints stiff when you get out of bed in the morning? ☐ Yes ☐ No

   If yes, how long does this stiffness last? _____

9. Do you have any pain? ☐ Yes ☐ No

   If yes, is the pain always there or does it come and go? ☐ Always there ☐ Comes and goes

10. If you have pain, please use the following scale to rate how bad your pain is in each of the following categories (at its, worst, at its least, etc.). Pick one number that best describes your pain.

0 = no pain	1	2	3	4	5	6	7	8	9	10 = worst pain	*Not applicable*

   At its worst: ___ At its least ___ On average ___ Right now ___

11. If you have low back pain, which of these positions makes your pain feel better:
    ☐ Rest ☐ Activity ☐ Sitting ☐ Standing ☐ Lying Down ☐ Other _____

12. If you have low back pain, which of these positions makes your pain feel worse:
    ☐ Rest ☐ Activity ☐ Sitting ☐ Standing ☐ Lying Down ☐ Other _____

13. Using the following scale, please rate to what extent your symptoms interfere with your general activity, mood, relationships, etc.:

0 = Does not interfere	1	2	3	4	5	6	7	8	9	10 = Completely interferes	*Not applicable*

    ☐ Your general activity ☐ Your mood
    ☐ Your ability to walk ☐ Normal work
    ☐ Relationships ☐ Sleep ☐ Enjoyment of life

14. What have you tried for relief? _____

_____

15. What currently gives you relief? _____

_____

16. Are you currently getting treatment for any other health problems? If so, please describe:

_____

_____

_____

Thank you for answering these questions.

Please turn over the page