HEALTH QUESTIONNAIRE

Fill in or circle your response as necessary. If you have any questions or are unclear on any of the following, please ask the receptionist for assistance.

EXPLAIN YOUR PROBLEM (SYMPTOMS) IN DETAIL_____

_____

HOW DID IT START_____ **WHEN DID IT START**_____

DOES THE PAIN RADIATE (seem to shoot or travel): YES / NO IF SO, FROM_____ **TO**_____

DESCRIBE THE TYPE OF PAIN: Sharp / Dull / Stabbing / Burning / Achy / Other_____

WHEN IS THE PAIN THE <u>WORST</u>: Morning / Day-time / Night / Constant Pain / Pain Only With Movement

DOES ANYTHING MAKE THE PAIN WORSE: Lifting / Stretching / Coughing / Sneezing / Twisting Right or Left / Straining at the Stool / Other_____

DOES ANYTHING MAKE THE PAIN DECREASE: Heat / Rest / Ice / Aspirin / Other_____

HAVE YOU HAD ANY MEDICAL TREATMENT FOR THIS PROBLEM: YES / NO IF SO, BY WHOM_____

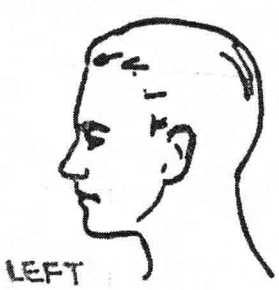
WHAT WAS THE TREATMENT: Surgery / Therapy - If so, what kind:_____ **/ Medications If so, what kinds:**_____ **/ Other**_____

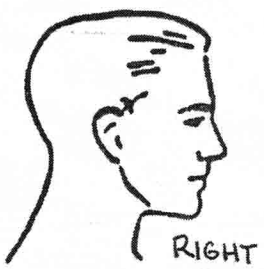
DID THIS TREATMENT HELP: YES / NO IF SO, FOR HOW LONG_____

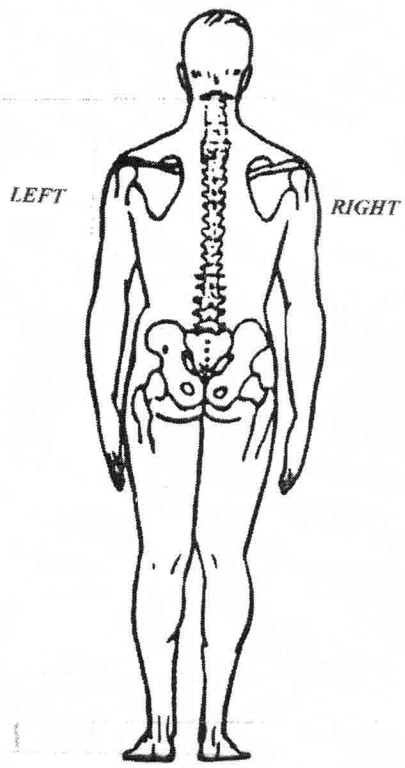
HAVE YOU EVER HAD THIS OR A SIMILAR PROBLEM BEFORE: YES / NO IF SO, WHEN_____

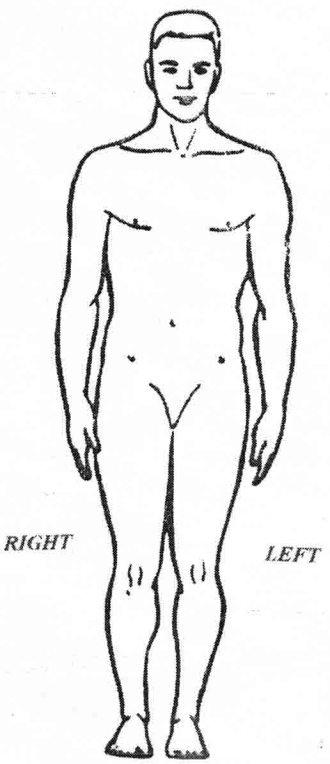
PAIN DRAWING

Please circle or X the location(s) of your pain and/or ache on the body diagrams below.









HOW SEVERE IS YOUR PAIN AND ACHE? PLEASE RATE AND LABEL EACH AREA SEPARATELY.

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

NO PAIN **WORST POSSIBLE**