Name: **DOB:**

PAIN AND PROBLEM QUESTIONNAIRE

DATE _____

What is the main reason for your office visit today (chief complaint): ☐ Right ☐ Left

Have you had any of the following (pertaining to this problem)? ☐ MRI ☐ X-rays ☐ CT ☐ Other _____

When did your symptoms first appear? _____
How long has this problem been present? _____Days _____Weeks _____Months _____Years

How did this begin: ☐ Gradual ☐ Suddenly ☐ After Injury ☐ No Known Mechanism of Injury
☐ Work-Related ☐ Work-Injury ☐ Motor Vehicle Crash

Please provide date of injury or accident:_____
Describe injury or accident:_____
_____

Circle the number that describes your pain **right now**? (for the specific problem you are being seen for today)

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

My pain is ☐ Not satisfactorily controlled ☐ Satisfactorily controlled

The pain feels (quality): ☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing
☐ Other:

The pain is (duration): ☐ Constant ☐ Comes and Goes (Intermittent)

Does your pain move anywhere? ☐ No ☐ Yes; where?

Are there any associated symptoms? ☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ Stiffness
☐ Locking ☐ Catching ☐ Giving Away ☐ Other:

Since your problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Medication (see below)
☐ Other:

What makes your symptoms worse? ☐ Activity ☐ Exercise ☐ Work ☐ Kneeling ☐ Bending ☐ Squatting
☐ Stooping ☐ Stairs ☐ Hills ☐ Running ☐ Walking ☐ Prolonged Sitting ☐ Other:

Does you pain or problem interfere with any of the following (check all that apply): ☐ General Activity ☐ Sports
☐ Normal Work ☐ Mood ☐ Enjoyment of life ☐ Ability to concentrate ☐ Relationship with others
☐ Other (Explain):

Please check if you are having any of the following?
☐ Fever/chills ☐ Unexpected Weight Loss ☐ Rashes ☐ Night pain ☐ Recent Trauma
☐ Problems with bowel or bladder function ☐ Groin Numbness ☐ Recent bacterial infection
☐ Suppressed Immune System ☐ Intravenous drug use ☐ Pain with coughing or sneezing

Please answer the following questions if you are a post-menopausal woman, or a man over age 65.

1. Have you ever had a bone density test?	☐ Yes	☐ No
2. Has someone in your family ever broken a hip or been told they have osteoporosis?	☐ Yes	☐ No
3. Is your diet low in calcium (avoid milk, cheese, yogurt, lactose intolerant)?	☐ Yes	☐ No
4. Do you have frequent/chronic diarrhea (Gluten intolerance, malabsorption)?	☐ Yes	☐ No
5. Do you weigh less than 125 pounds?	☐ Yes	☐ No
6. Have you fallen down 2 or more times in the last year?	☐ Yes	☐ No
7. Do you have rheumatoid arthritis?	☐ Yes	☐ No
8. Have you taken steroids (Cortisone, Prednisone) for 3 or more months in your life?	☐ Yes	☐ No
9. Have you been treated for cancer with chemotherapy or other medication?	☐ Yes	☐ No
10. Do you take medication for epilepsy or a seizure disorder?	☐ Yes	☐ No
11. Do you currently smoke?	☐ Yes	☐ No
12. Do you drink 3 or more alcoholic drinks per day?	☐ Yes	☐ No
13. Do you drink 3 or more caffeinated drinks (coffee, tea, soda) per day?	☐ Yes	☐ No
14. Have you broken any bones (after the age of 50)?	☐ Yes	☐ No
15. Do you walk or jog for exercise?	☐ Yes	☐ No

Physician' Initial: _____ Date: _____