Patient Interview Form

CHIEF COMPLAINT: _____

LOCATION OF PAIN: _____

SEVERITY OF PAIN: mild 1 2 3 4 5 6 7 8 9 10 excruciating

RADIATION OF PAIN: (WHERE DOES PAIN GO TO?)_____

ONSET OF PAIN: (TIME AND EVENT IN DETAIL) _____

_____

QUALITY OF PAIN: (e.g., SHARP, DULL, NUMBING, TINGLING, BURNING, PINS AND NEEDLES, etc)

_____

WORSENING FACTORS: (WHAT MOVEMENT MAKES PAIN WORSE)_____

_____

RELIEVING FACTORS: _____

PAST HISTORY OF SIMILAR SYMPTOMS, IF ANY INCLUDING DETAILS OF SUCH _____

_____

CURRENT TREATMENT SO FAR: MEDS, THERAPY, SURGERY, IMAGING STUDIES (e.g. MRI, CT, X-ray, EMG, ETC) _____

PAST MEDICAL HISTORY:_____

PAST SURGICAL HISTORY:_____

ALLERGIES:_____

CURRENT MEDICATIONS: _____

SOCICAL HISTORY: If Yes include information on how much and how often

SMOKE N Y_____

DRINK N Y_____

ILICIT STREET DRUGS N Y_____

SINGLE MARRIED DIVORCED WIDOWED KIDS

TYPE OF WORK: PHYSICAL vs DESK JOB