Healthy Living Natural Health & Pain Management Center

Pain/Numbness Questionnaire

Name: _____ Email: _____ Phone: _____ Date: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth _____/_____/_____ Age: _____ Height: _____ Weight: _____
Primary Care Physician: _____ Referring Physician: _____
How did you hear about us? _____

Education:
____High School ____Advanced Degree/Vocational Degree ____College Graduate

Marital Status:
_____Single _____Married (How Long?)_____ _____Divorced _____Widowed

Number of Children: _____
If married, please give spouse's occupation: _____

Current Occupation or Last Job: _____
Current Employment Status:
_____Full-Time _____Part-Time _____Unemployed
_____Homemaker _____Retired _____Student

Are you receiving compensation or disability payments now? ____Yes ____No
If yes, are payments adequate? ____Yes ____No
Do you have an application for compensation or disability payments pending? ____Yes ____No

Is your pain or numbness the result of an accident? ____Yes ____No
If yes, where did it occur? Circle one: Home Work Vacation Car Other
Describe: _____

Pain / Numbness / Neuropathy Information:

What is the main problem for which you are seeking treatment today? _____
_____

Are there any other complaints or problems you'd like to be treated? _____
_____

Please describe the location of your pain or numbness: _____
_____

How long have you had your current pain or numbness problem? _____
_____

How did your current pain or numbness start? Was there a precipitating event? _____
_____

How do the following affect your pain, numbness or tingling? (please circle one for each item)

Lying Down	Decrease	No Effect	Increase
Standing	Decrease	No Effect	Increase
Sitting	Decrease	No Effect	Increase
Walking	Decrease	No Effect	Increase
Exercise	Decrease	No Effect	Increase
Medication	Decrease	No Effect	Increase

Are there other factors that make your pain, numbness or tingling…

Better? _____

Worse? _____

Please rate the intensity of your pain, numbness, or tingling on a scale from 0 (no pain) to 10 (excruciating, incapacitating, worst possible). Rate your pain, numbness, or tingling during the past month:

Your pain, numbness at its worst: _____
Your pain, numbness at its least: _____
Your average pain, numbness: _____
Your current pain, numbness: _____

How often do you have your pain, numbness, or tingling?

_____Constantly (100% of the time) _____Nearly constantly (60-99% of time)
_____Intermittently (30-60% of time) _____Occasionally (less than 30% of time)

Have you ever had a psychiatric, psychological, or social work evaluation for any problem (including your current pain)? ____Y ____N

If yes, what and when? _____

Please circle all of the treatments you have tried for your pain, numbness, or tingling:

Hospital bed rest Traction Surgery Exercise

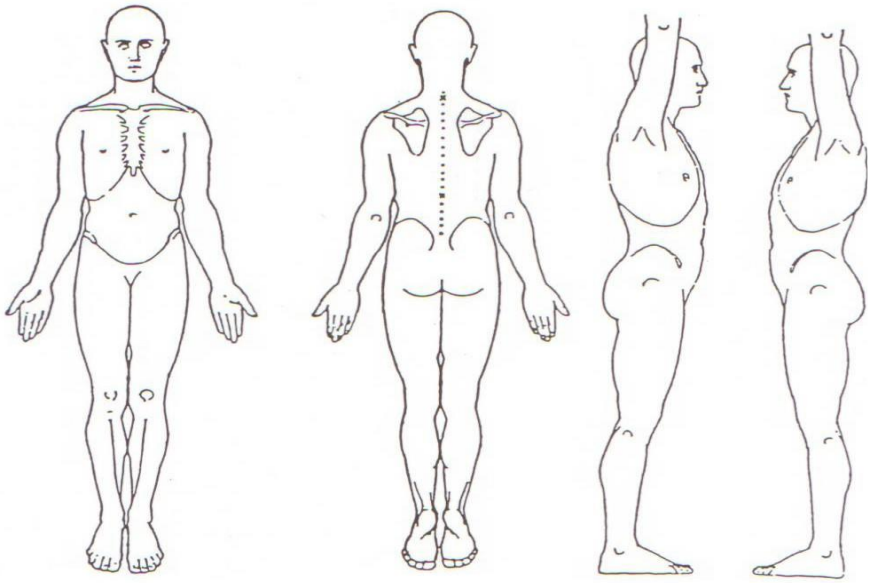
Nerve block or injection TENS (electrical stimulation) Physical Therapy

Psychotherapy Other:_____

Which ones helped you the most? _____

Which ones helped you the least? _____

Have you ever been in treatment for misuse of alcohol or drugs? ____Yes ____No
If yes, where and when? _____



Mark the areas that you are experiencing your pain, numbness, or tingling. Indicate the type of pain or numbness you are experiencing by marking with letters.

a) deep (inside)
b) superficial (on the skin)
c) constant (all the time)
d) intermittent (starts and stops)
e) aching
f) burning
g) shooting

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you once you become a patient, and you are personally responsible for payment. This office does not accept insurance of any kind. The services provided are not covered by insurance due to the natural, alternative approach we use here. Your signature also indicates that you authorize the staff to perform any necessary services needed during diagnosis and treatment.

I understand the above information and guarantee that this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I provided.

Patient Signature: _____ Date: _____

Office Use Only: _____

_____

_____

_____

_____

_____

_____

History: _____

_____

History:

Overall Health (circle one) Excellent Good Fair Poor Other: _____

List any major illnesses (with approx. dates): _____
_____

List any surgery or operations with approx. dates :_____
_____

Past accidents or injuries: _____
_____

Any family history of serious illnesses (circle all that apply): Cancer Diabetes Heart
Other: _____

Current medications: _____
_____
_____

Nutritional Supplements you are taking: _____
_____
_____

Previous Chiropractic Care: None _____ Dr's name & approx. date of last visit: _____
_____

Do you smoke, drink coffee or drink alcohol? (if yes, indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Any household pets or other animals you or your family members are in close contact with:_____
_____