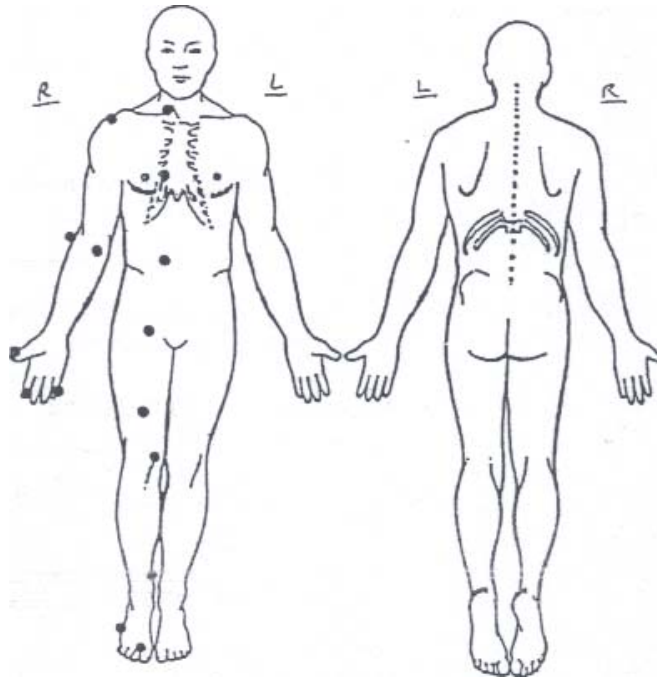


Physical Medicine and Rehabilitation Questionnaire

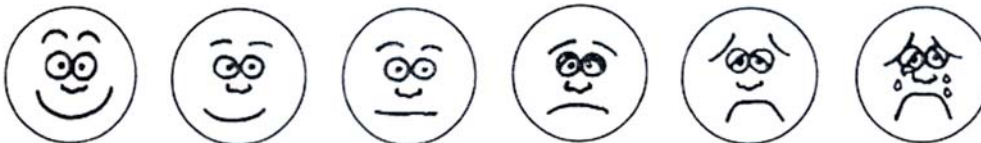
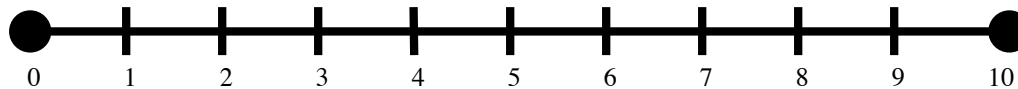
Name: _____ Date: _____

Referring Physician: _____

- 1) Please **circle** on the diagram below the areas **where you feel pain**.
- 2) If your **pain moves**, please draw arrows on the diagram to indicate this movement.
- 3) If you feel **numbness or tingling**, draw an "x" on the diagram to indicate areas you feel it.



- 4) Using the scale below, please indicate how bad your pain is:
 - a. At its **worst** (0-10) _____
 - b. At its **least** (0-10) _____
 - c. As it is **right now** (0-10) _____



0	2	4	6	8	10
No Hurt	Hurts a Little Bit	Hurts a Little More	Hurts Even More	Hurts a Whole Lot	Worst

If your pain is due to an injury, what was the date of injury? _____

5) What started your pain or what were you doing when your pain started? _____

Please circle one:

7) Do you feel you have weakness? Yes No

8) Do you have back/neck muscle spasms? Yes No

9) Do you have arm/leg cramps? Yes No

10) Do you have headaches along with the other pain? Yes No

11) How many years have you been having pain?

- a. less than one year
- b. one to 10 years
- c. more than 10 years

12) When did your most recent episode of pain start?

- a. less than a month ago
- b. within the last one to three months
- c. more than three months ago

13) Which best describes the duration of your pain?

- a. constant
- b. intermittent

14) During which part of the day is your pain the worst?

- a. Morning
- b. afternoon
- c. evening
- d. night

Please circle ALL that apply:

15) How would you **describe** your pain?

- a. aching
- b. throbbing
- c. shooting
- d. stabbing
- e. burning
- f. sharp
- g. dull
- h. (other) _____

16) What makes your pain better?

- a. standing
- b. sitting
- c. walking
- d. lying
- e. heat
- f. ice
- g. stretching
- h. medications
- i. nothing

17) What makes your pain worse?

- a. standing
- b. sitting/driving
- c. walking
- d. lying
- e. coughing/sneezing/straining
- f. other

- 18) Have you tried?
- a. physical therapy
 - b. acupuncture
 - c. chiropractic care
 - d. epidural/cortisone injections
 - e. surgery
 - f. none of the above

- 19) For the body part in pain, have you had?
- a. X-rays
 - b. CT scans
 - c. MRI
 - d. bone scan
 - e. none of the above

- 20) What **medical conditions** do you have?
- a. heart disease
 - b. high blood pressure
 - c. diabetes
 - d. stomach ulcers
 - e. stroke
 - f. arthritis
 - g. glaucoma
 - h. cataracts
 - i. kidney disease
 - j. chronic/active infection
 - k. cancer
 - l. depression
 - m. bi-polar disorder
 - n. other
 - _____
 - o. none

- 21) What **surgeries** have you had?
- a. neck
 - b. back
 - c. hip
 - d. shoulder
 - e. knee
 - f. foot
 - g. carpal tunnel
 - h. other
 - _____
 - i. none

- 22) What is your **family history** of medical conditions?
- a. arthritis
 - b. heart disease
 - c. stroke
 - d. cancer
 - e. diabetes
 - f. high blood pressure
 - g. other
 - _____
 - h. none

Please circle or fill in the blank:

23) If applicable, can you list the cause of death of any of your family members?
 (i.e., grandparents, parents, siblings, children)

24) Are you? married single divorced separated widowed

25) If you are a parent, what are the ages of your **children**? _____

26) Do you? smoke drink alcohol use marijuana/illicit drugs none

