Patient Name:  
DOB:  
MR #:  

Index to Questionnaire – Health\Encounter
Date: ______________________________________________________________

Referred by: ___________________________      Primary Care Provider: ________________________________

Describe brief history of the pain problem you were sent here for: ______________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

How long has pain been present? ________________   Work-related? □ Yes □ No            Legal case? □ Yes □ No
Describe the pain (burning, sharp, etc.): __________________________________________________________________
What makes the pain worse? ___________________________________________________________________________
What makes the pain better? ___________________________________________________________________________
How do you spend your day? ___________________________________________________________________________

You use a: □ Cane □ Crutches □ Walker □ Scooter □ Wheelchair
Handedness: □ Left □ Right

TREATMENT: If you have tried any of these treatments, right ↑ if helpful, ↓ if made worse, _ if no difference.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy (PT)</td>
<td>Heat</td>
<td></td>
<td>Trigger point injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (OT)</td>
<td>Cold</td>
<td></td>
<td>Spinal injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercises</td>
<td>Traction</td>
<td></td>
<td>Implanted pump</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water exercise/aerobics</td>
<td>Acupuncture</td>
<td></td>
<td>Implanted stimulator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splints or braces</td>
<td>Chiropractic</td>
<td></td>
<td>Nerve blocks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological care for pain</td>
<td>Meditation/relaxation</td>
<td></td>
<td>Nerve ablation/burning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain management classes</td>
<td>Massage</td>
<td></td>
<td>TENS unit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SLEEP: Please check all that apply to you:

□ Trouble falling asleep □ Snore □ Restless legs □ Fatigued much of the time
□ Nap during the day □ Sleep apnea □ Use CPAP □ Wake in the middle of the night

EXERCISE: What you do for exercise: ______________ How often? __________ For how long each time? _________

MOOD: Describe your current emotional state (check all that apply):

□ Happy □ Optimistic □ Well-adjusted □ Angry □ Hopeless
□ Depressed □ Suicidal □ Anxious □ Confused □ Indifferent

Please indicate if you have a history of (check all that apply):

□ Depression □ Anxiety □ Attention deficit □ Bipolar disorder
□ Suicide attempt(s) □ Abuse experiences □ Other problems: ________________________________

Are you currently seeing a psychiatrist? □ Yes □ No     If yes, name: _________________________

Are you currently seeing a counselor and/or psychologist? □ Yes □ No     If yes, name(s): ______________________________

UWH4002755-DT (Rev. 05/27/20)
HOME / SCHOOL: Who lives with you? __________________________________________________________________

Marital Status: □ Married □ Single □ Engaged □ Divorced □ Separated □ Widowed

If you have children, how many and ages: ________________________________________________________________

Highest grade reached in school: _______________     Have you spent time in the military? □ Yes □ No

WORK: Do you work outside the home?

□ Yes. If yes, occupation: _______________________

□ Full-time □ Part-time □ Light/limited duty

Do/did you miss work due to pain? □ Yes □ No

□ No. If no, when did you last work? ______________      Why did you stop working? ______________________

If no, source of income: ___________________      Do you intend to return to work? □ Yes □ No

MEDICATIONS: Please bring a complete list of your current medications to your clinic appointment. Bring current pill bottles (with pills) if possible.

What medications have you tried to treat your pain condition? (Please check all that apply)

□ Vitamins □ Herbs □ Glucosamine □ Other supplements: ________________ □ Helpful □ Not helpful

Over-the-counter Pain Relievers:

□ Tylenol □ Generic acetaminophen □ Aleve □ Naproxen

□ Generic ibuprofen □ Celebrex □ Others: ________________ □ Helpful □ Not helpful

Opioids/narcotics:

□ Oxycodone □ Hydrocodone □ Percocet □ Vicodin □ Morphine

□ Dilaudid □ Fentanyl □ Butrans □ Methadone □ Suboxone

□ Kadian □ Tramadol □ Nucynta □ Other(s): ___________________ □ Helpful □ Not helpful

Muscle Relaxants:

□ Carisoprodol □ Cyclobenzaprine □ Skelaxin □ Baclofen □ Tizanidine

□ Other(s): ___________________ □ Helpful □ Not helpful

Anti-seizure Medications:

□ Gabapentin □ Lyrica □ Pregabalin □ Topamax □ Topiramate

□ Other(s): ___________________ □ Helpful □ Not helpful

Antidepressants:

□ Amitriptyline □ Nortriptyline □ Cymbalta □ Duloxetine □ Sertraline

□ Escitalopram □ Paroxetine □ Fluoxetine □ Savella □ Milnacipran

□ Other(s): ___________________ □ Helpful □ Not helpful

Sedatives/Anti-anxiety Medications:

□ Diazepam □ Lorazepam □ Clonazepam □ Other(s): ________________ □ Helpful □ Not helpful

Sleeping Aids:

□ Benadryl □ Diphenhydramine □ Ambien □ Zolpidem □ Sonata

□ Other(s): ___________________ □ Helpful □ Not helpful

Topicals:

□ Lidoderm patch □ Lidocaine cream □ Ben-Gay □ Capsaicin □ Qutenza

□ Tiger Balm □ Voltaren gel □ Other(s): ___________________ □ Helpful □ Not helpful
HABITS: □ I have never smoked   □ I currently smoke   □ I have quit smoking   □ I chew tobacco or inhale snuff
Average number of caffeinated beverages per day: ____________
I have about _______ alcoholic drinks per □ day  □ week  □ month (check appropriate time period).
I have used non-prescribed drugs: □ Yes □ No
If yes, check appropriate boxes:
☐ Marijuana ☐ Now ☐ In the past
☐ Cocaine ☐ Now ☐ In the past
☐ Heroin ☐ Now ☐ In the past
☐ Amphetamines ☐ Now ☐ In the past
☐ CBD ☐ Now ☐ In the past
☐ Fentanyl ☐ Now ☐ In the past
☐ Opioid Pills ☐ Now ☐ In the past
☐ Kratom ☐ Now ☐ In the past
☐ Other(s): ____________________________________ ☐ Now ☐ In the past

ALCOHOL / DRUG ADDICTION (please select all that apply):
☐ I have a history of alcohol and/or drug addiction.   ☐ I have been treated for addiction.
☐ I am in treatment now.   ☐ I need treatment

HEALTH HISTORY: Please check the items that apply to you. Provide details at right.

General:
☐ Fatigue   ☐ Fevers/Chills   ☐ Weight loss/gain   ☐ Night sweats   ☐ Hot flashes
Details or other problems:

Head/Neck:
☐ Poor vision   ☐ Poor hearing   ☐ TMJ   ☐ Head/neck cancer   ☐ Swollen glands/nodes
Details or other problems:

Blood/Immune:
☐ Easy bruising/bleeding   ☐ Anemia   ☐ Lymphoma or leukemia   ☐ Transfusions   ☐ Transplant
Details or other problems:

Bones/Joints:
☐ Broken bones   ☐ Joint swelling   ☐ Stiff joints   ☐ Osteoarthritis   ☐ Very flexible joints
☐ Morning stiffness   ☐ Lupus   ☐ Rheumatoid
Details or other problems:

Skin:
☐ Rashes   ☐ Sores/ulcers   ☐ Scars   ☐ Eczema   ☐ Skin cancer
Details or other problems:

Lungs/Chest:
☐ Shortness of breath   ☐ Cough   ☐ Asthma   ☐ Emphysema/COPD   ☐ Pneumonia
☐ Lung cancer   ☐ Lung surgery
Details or other problems:

Heart:
☐ Chest pain (from heart/Angina)   ☐ High blood pressure   ☐ Heart attack   ☐ Low blood pressure   ☐ Irregular heartbeat
☐ Valvular disease   ☐ Swollen legs/arms   ☐ Aneurysm   ☐ Cold hands/feet
Details or other problems:

Spine:
☐ Scoliosis   ☐ Disc problems   ☐ Fracture   ☐ Neck injury   ☐ Back injury
☐ Spinal arthritis   ☐ Spine surgery   ☐ Spinal tumor
Details or other problems:

Endocrine:
☐ Diabetes   ☐ Goiter   ☐ Thyroid disease   ☐ Low testosterone / estrogen   ☐ Pancreatic disease
Details or other problems:
Genital / Urinary and Pelvic:
- Kidney stones
- Kidney failure
- Kidney cancer
- Prostate problem
- Urinary infection
- Problems controlling urine
- “Fallen bladder”
- Painful intercourse
- Erectile dysfunction
- Prostate/bladder cancer
- Menstrual problems
- Pelvic pain
- Ovarian / uterine / cervical cancer

Details or other problems:
- Kidney stones
- Kidney failure
- Kidney cancer
- Prostate problem
- Urinary infection

Abdomen/GI:
- Heartburn/GERD/Hiatal hernia
- Peptic ulcer
- Gallstones
- Hepatitis
- Diarrhea
- Constipation
- Irritable bowel
- Ostomy
- Crohn’s disease
- Ulcerative colitis
- Cancer
- Gastric bypass
- Problems controlling bowels
- Blood in stool
- Liver disease

Details or other problems:
- Heartburn/GERD/Hiatal hernia
- Peptic ulcer
- Gallstones
- Hepatitis
- Diarrhea

Neuro-Muscular:
- Headache
- Vertigo (spinning)
- Lightheadedness
- Stroke
- Seizures/epilepsy
- Tremor
- Falls
- Balance problems
- Weakness
- Muscle pain
- Fibromyalgia
- CRPS/RSD
- Brain tumor
- Parkinson’s
- Multiple sclerosis
- Double vision
- Peripheral neuropathy
- Chronic fatigue
- Spinal cord injury
- Muscular dystrophy or myopathy
- Head injury/concussion

Details or other problems:
- Headache
- Vertigo (spinning)
- Lightheadedness
- Stroke
- Seizures/epilepsy

Other:
- Now pregnant
- Now breastfeeding
- Planning pregnancy
- HIV infection
- Artificial joint or disc
- Cancer
- Pacemaker, defibrillator, stent(s), artificial heart valve(s)

OTHER MEDICAL HISTORY:

SURGICAL HISTORY:

FAMILY MEDICAL HISTORY:

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>MEDICAL PROBLEM(S)</th>
<th>FAMILY MEMBER</th>
<th>MEDICAL PROBLEM(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Child</td>
<td>Mother</td>
<td>Child</td>
</tr>
<tr>
<td>Sibling</td>
<td>Others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Patient/Representative: ____________________________ Date: __________ Time: __________

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: ____________________________ Relationship: ____________________________

Patient is:  □ Minor     □ Incompetent/Incapacitated

Legal Authority:  □ Legal Guardian  □ Parent of Minor

Reviewed by: ____________________________ Date: __________ Time: __________