Name_____Date_____Date first Symptoms_____
Age_____Allergies_____Height_____Weight_____Handed: R/L
How did you find me? _____
Medications (prescription, over the counter, anti-inflammatories, vitamins, supplements)

_____

_____

_____

How did your current problem start? _____
Where is your pain located? _____
When do you have discomfort? constant, daily, intermittent, with rest, with activity, prolonged position, driving

_____

Are you feeling better? _____ Are you moving better? _____ Can you do more? _____
Does the pain spread to your arms or legs? _____
Do you have any pins & needles or numbness or weakness? _____
Do you "pop, crack or grind" when you move? _____
What position or activity makes you feel better? _____
What position or activity makes you feel worse? _____
When is your best time of day? _____ When is your worst time of day? _____
Do you have pain with coughing or sneezing? _____
Do you have problems with your bowels or bladder? _____

Previous history of the same symptoms? _____
Previous injuries? childhood, work, sports_____
Previous auto accidents? treatment, did you fully recover? _____

_____

What imaging studies have you had (please circle) MRI, x-rays, CT scan, myelogram, EMG (nerve test), bone scan, discogram, arthrogram
Part of body and result? (please provide copies of reports)_____

What treatment have you had? (please circle all that apply)
physical therapy. massage, home stretch, exercise, Chiropractic adjustments, Osteopathic manipulation, acupuncture, counseling, biofeedback, injections(steroid, prolotherapy, epidural, trigger point, facet, sacroiliac), surgery, Rolfing, Feldenkrais, Pilates, pool, health club, theracane, theraband, exercise ball, video tapes, orthotics, heel lifts, mouth splint, TENS unit, traction, _____

How long did you go, how many visits? _____
What helps the most? _____
How long do you get relief following therapy? _____
Do your symptoms return? _____ Do your symptoms improve? _____

Who else have you seen for this problem and when? _____

_____

Do you get regular exercise? _____ Has this changed? _____
Type? _____ How often? _____
Do you smoke? _____ How many packs per day? _____ Years? _____
How much alcohol in a week? _____
Caffeine in a day? coffee, tea, pop_____

Occupation? _____

Does your job involve: lifting (lbs._____), twisting, bending, climbing, push/pull, repetition, desk, computer, phone
Have you missed any work due to your current condition?

_____

Are you on any work restrictions? _____

Hobbies? _____
Marital status? _____Children? _____
Are there things you have trouble doing around the house? _____
Have you had essential services or help around the house? _____

Can you find a position of comfort when you sleep? _____
Do you sleep on your? (circle) side back stomach
Can you sleep through the night? _____ Do you wake with pain? _____
Do you wake feeling refreshed? _____
How many hours per night do you sleep? _____
What type of pillow do you use and how many? _____Mattress type, age?_____
Do you put a pillow between or under your knees? _____

Who is your Primary Care? _____
Do you have any non-musculoskeletal medical problems?

_____

eyes, ears, nose, throat, heart, blood pressure, asthma, hepatitis, infectious disease, headache, skin, sleep apnea, neurological disorders, seizure, ulcers, arthritis, diabetes, thyroid, bleeding, cancer, osteoporosis

Any changes in your health history? _____
Previous surgery? _____
Family history:
Mother? _____
Father? _____
Brothers? _____Sisters? _____

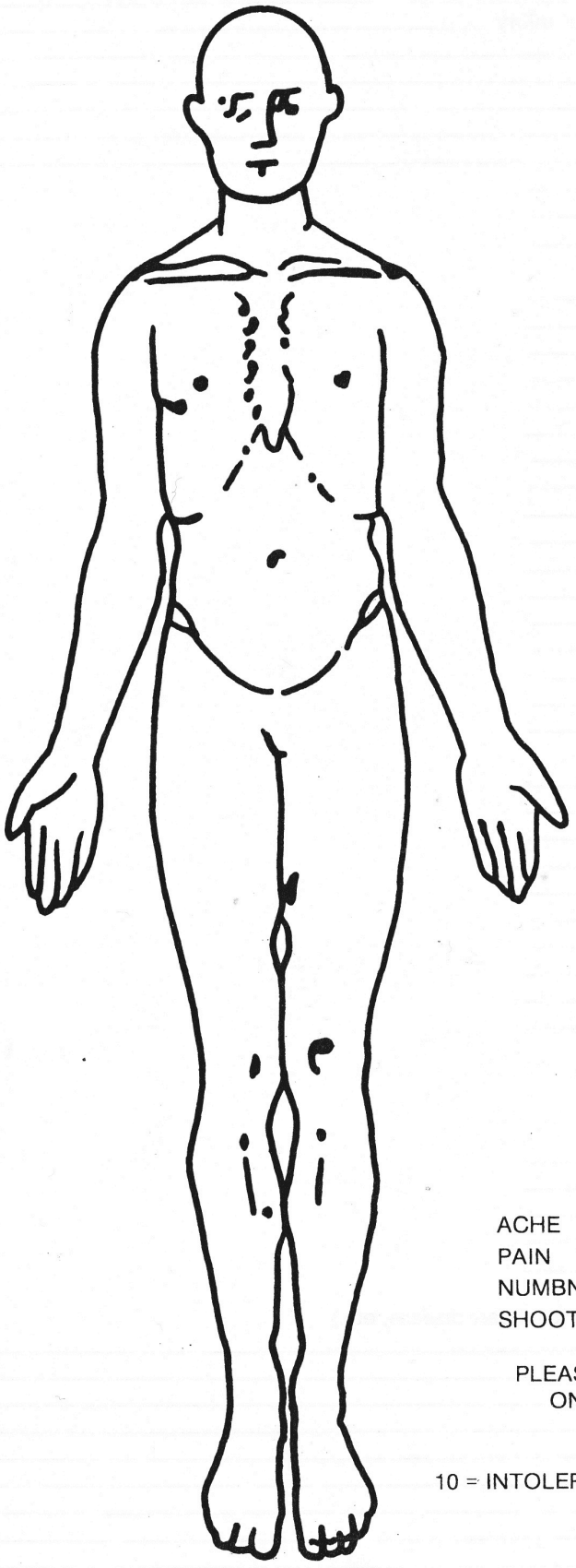
Do you have any of the following symptoms? (please circle)

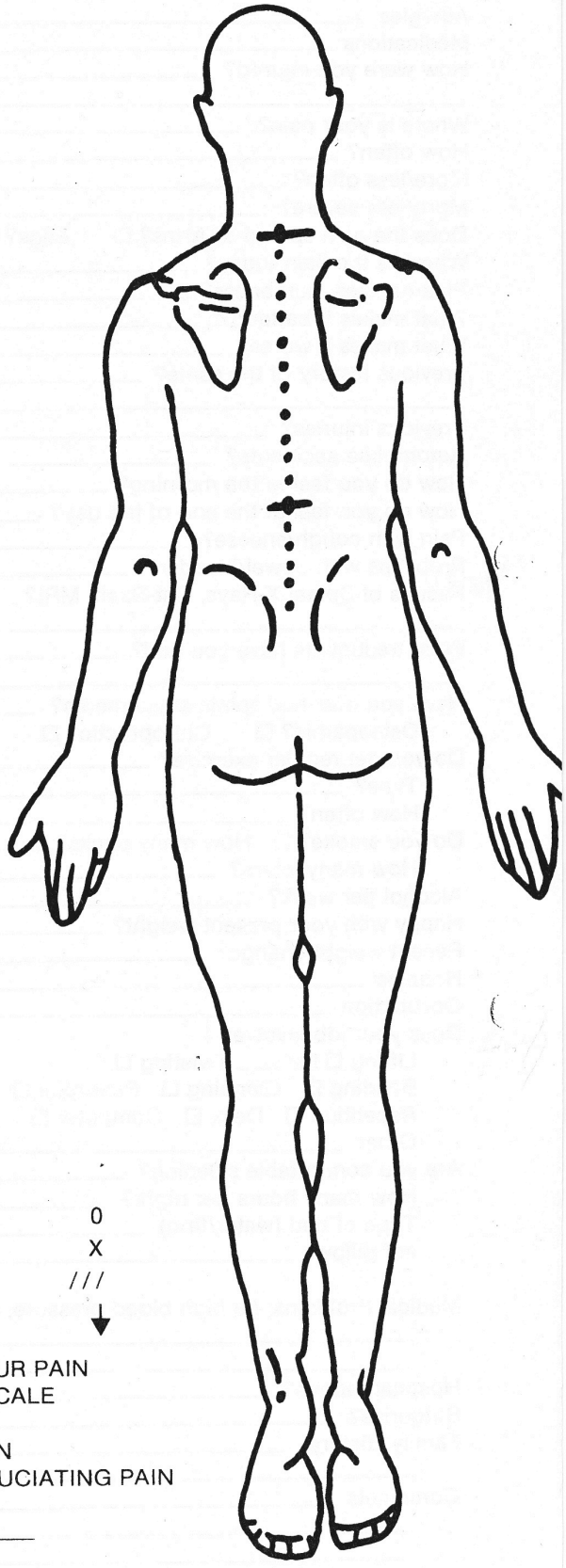
Recent weight change, fever, chills, fatigue, weakness, pain down arms or legs, numbness, joint stiffness or pain, swelling, limited motion, neck or back pain, muscle cramps, night pain, deformities, scoliosis, loose joints or double-jointed, dislocations, night sweats, easy bruising or bleeding, headache, dizziness, prostate problems, tremors, unsteady gait, difficulty getting to sleep or staying asleep,
restless legs, depression.

Do you have any questions for me?

_____
_____
_____

DATE _____ NAME _____





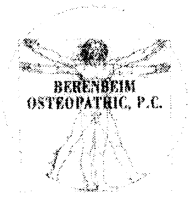
ACHE	0
PAIN	X
NUMBNESS	///
SHOOTING PAIN	↓

PLEASE RATE YOUR PAIN
ON A 0 — 10 SCALE

0 = NO PAIN
10 = INTOLERABLE EXCRUCIATING PAIN

average _____

at it's worst _____



DALLAS PAIN QUESTIONNAIRE

Name_____

Date_____ Date of Injury_____

Please read: This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0-100 in each section.

Section I: Pain and Intensity
To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None Some All the time
0%(_____:_____:_____:_____:_____:_____)100%

Section II: Personal Care
How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc)?

None(no pain) Some I can't get out of bed
0%(_____:_____:_____:_____:_____:_____)100%

Section III: Lifting
How much limitation do you notice in lifting?

None Some I can't lift anything
0%(_____:_____:_____:_____:_____:_____)100%

Section IV: Walking
Compared to how far you could walk before your injury or back trouble, how much does pain restrict walking now?

The same Almost the same Very little I cannot walk
0%(_____:_____:_____:_____:_____:_____)100%

Section V: Sitting
Back pain limits my sitting in a chair to:

None Some I can't sit at all
0%(_____:_____:_____:_____:_____:_____)100%

Section VI: Standing
How much does pain interfere with your tolerance to stand for long periods?

None(same as before) Some I can't stand
0%(_____:_____:_____:_____:_____:_____)100%

Section VII: Sleeping
How much does pain interfere with your sleeping?

None(same as before) Some I can't sleep at all
0%(_____:_____:_____:_____:_____)100%

Section VIII: Social Life
How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc.)?

None Some No activities
0%(_____:_____:_____:_____:_____:_____:_____:_____)100%

Section IX: Traveling
How much does pain interfere with traveling in a car?

None Some I can't travel
0%(_____:_____:_____:_____:_____:_____:_____)100%

Section X: Vocational
How much does pain interfere with your job?

None Some I can't work
0%(_____:_____:_____:_____:_____:_____:_____:_____)100%

Section XI: Anxiety/Mood
How much control do you feel that you have over demands made on you?

Total (no change) Some
None
0%(_____:_____:_____:_____:_____:_____:_____)100%

Section XII: Emotional Control
How much control do you feel you have over your emotions?

Total (no change) Some
None
0%(_____:_____:_____:_____:_____:_____:_____:_____)100%

Section XIII: Depression
How depressed have you been since the onset of pain?

Not depressed significantly Overwhelmed by depression
0%(_____:_____:_____:_____:_____:_____:_____:_____)100%

Section XIV: Interpersonal Relationships
How much do you think your pain has changed your relationships with others?

Not changed Drastically changed
0%(_____:_____:_____:_____:_____:_____:_____:_____)100%

Section XV: Social Support
How much support do you need from others to help you during this onset of pain (taking over chores, meals, etc)?

None needed All the time
0%(_____:_____:_____:_____:_____:_____:_____)100%

Section XVI: Punishing Response
How much do you think others express irritation, frustration or anger toward you because of your pain?

None Some All the time
0%(_____:_____:_____:_____:_____:_____:_____)100%

I-VIIx3=_____ VIII-Xx5=_____ XI-XIIIx5=_____ XIV-XVIx5=_____