

The Rose Center for Rehabilitation, Hope and Wellness

PATIENT HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Occupation: _____

1. Where is your pain/problem: _____
2. Date of onset of the pain / surgery / injury (circle one): _____
3. Briefly describe how / why your pain started: _____

4. The pain is currently getting: (circle one) Better Worse Same Activity dependent
5. Pain Level: _____ Scale 0=no pain-----moderate pain-----10=severe pain - going to E.R
6. Stress Level: _____ Scale 0= no stress----moderate -----10 =severe stress
7. Action or positions that make the pain worse:

TMJ

- Chewing
- swallowing
- clenching
- grinding
- wakes me at night
- talking
- closing the mouth
- opening the mouth
- lying on my side R/L
- wearing my splint

Habits:

- bite my nails
- chew gum /hard candy
- chew ice cubes
- chew my cheek
- chew items

Do you have:

- a splint
- dentures
- a retainer
- partials
- Headaches assoc. with jaw pain

Neck / Upper back / Spine

- looking down
- looking up
- sitting _____min.
- standing _____min.
- exercise during/after
- Other: _____
- coughing
- sneezing
- walking
- lying down
- wakes me at night
- using a computer
- reaching up/ using arms
- talking on the phone

8. Actions or positions that make you better: _____ splint therapy - wearing the splint - when? _____

9. Is your pain: better in the morning better at the end of the day activity dependent
 worse in the morning worse at the end of the day

10. Additional comments that might be helpful in your treatment: _____

Headaches: how often - _____

HEALTH INFORMATION

11. Past Medical History:

- cancer
- arthritis/RA
- diabetes
- pregnant
- wore braces _____
- heart _____
- pacemaker/metal implant
- migraine headaches

13. Diagnostic studies:

	Yes	No	Date
Diagnostic x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthrogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____

12. Medication: please list or provide a list: _____

14. Allergies: _____

15. Have you been hospitalized for this problem?

Yes No Date: _____

Please complete the back of the form.

17. What other healthcare providers have you seen for this condition? _____

TODAY

18. Where is your pain today: _____

19. Pain level: _____

20. Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Also mark the areas where the pain spreads.

Aching
AAAAAA

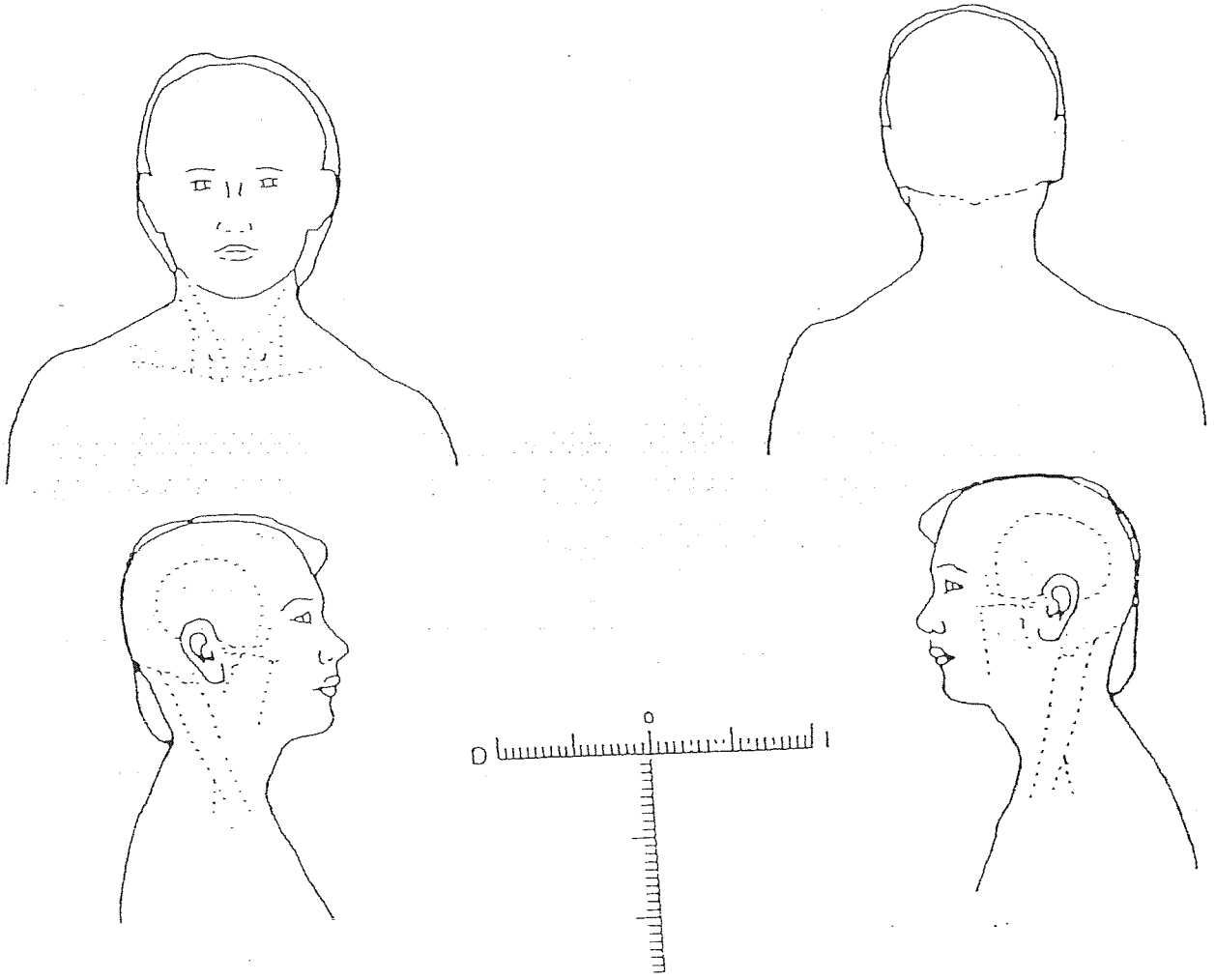
Numbness
>>>>>

Pins and Needles
OOOOO

Burning
XXXXX

Stabbing
IIIIII

"Sore"
JJJJJ



Reviewed by _____