OHIO PAIN & REHAB SPECIALISTS
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HEALTH QUESTIONNAIRE

www.ohiorehab.com

PERSONAL DATA:

Name:_____Age:_____Height:_____Weight:_____
Referred by?_____ Family Physician?_____

CHIEF COMPLAINT: (What is the reason for your visit?)_____

_____

HISTORY OF PRESENT PROBLEM: When did your symptoms begin?_____
□ Work Injury □ Auto Accident □ Spontaneous Onset □ Other_____
BRIEFLY DESCRIBE:_____

_____

Ever had such symptoms in the past? □ Yes □ No Explain:_____

Past treatments: □ Physical Therapy □ Chiropractic □ Nerve block □ Epidural injection □ Biofeedback
□ Surgery □ Other:_____Briefly describe response:_____
Past tests: □ Labs □ X-rays □ MRI □ EMG□ Other:_____
Since the onset of your problem, have your symptoms changed? □ Yes □ No If so, how?_____

_____

Are your symptoms: □ Constant □ Sharp □ Stabbing □ Burning □ Throbbing □ Intermittent □ Dull
□ Shooting □ Aching □ Other_____
Do you experience: □ Numbness □ Tingling □ Weakness □ Other:_____
What increases your pain?: □ Walking □ Lifting □ Lying □ Twisting □ Sitting □ Bending □ Standing
□ Reaching □ Other:_____
What decreases your pain? □ Heat □ Rest □ Reclining □ Sitting □ Walking □ Ice □ Activity □ Standing
□ Other:_____
Does pain interfere with? □ Work □ Daily Activities □ Social Life □ Hobbies □ Relationships
Where would you rate your pain? (mark an "x" on the line)

_____

No pain Worst Pain Imaginable

Current Medications

Medication Names	Strength	Times per Day	Condition Being Treated

PHARMACY NAME & CITY_____

PHARMACY PHONE NUMBER_____

VITAMINS/SUPPLEMENTS_____

_____

ALLERGIES? (Medication, food/other)_____

OVER

MEDICAL HISTORY: Please check all that apply.

□ Stroke □ Heart Attack □ High blood pressure □ COPD/asthma □ Blood clots
□ Coronary artery disease □ Peripheral vascular disease/circulation problems
□ Diabetes □ Kidney disease □ Hepatitis □ Thyroid disease □ Cancer
□ Coagulation disorder □ Gastritis/ulcers/reflux □ Psychiatric treatments □ HIV/AIDS
□ Left hand dominant □ Right hand dominant
□Other:_____

PAST SURGERIES OR HOSPITALIZATIONS (AND YEAR): _____

_____

SOCIAL HISTORY:

Occupation:_____□Full time □ Part time □ Retired □ Not working □ Disability
Marital Status: **S M D W** Sep # of Children:_____
Do you have a history of drug or alcohol abuse/dependency? □Yes □ No
Tobacco use: □No □ Yes _____Pack per day_____Years □ Former smoker
Alcohol use: □No □ Yes _____drinks per week

FAMILY HISTORY- (Please **CIRCLE <u>RELATIONSHIP</u>** of family member and also **YES** or **NO**)

Diabetes (mother/father/sibling)	Y	N	Cancer (mother/father/sibling)	Y	N
High blood pressure (mother/father/sibling)	Y	N	Lupus (mother/father/sibling)	Y	N
Heart disease (mother/father/sibling)	Y	N	Fibromyalgia (mother/father/sibling)	Y	N
Rheumatoid Arthritis (mother/father/sibling)	Y	N	Stroke (mother/father/sibling)	Y	N

AT THE PRESENT TIME ARE YOU EXPERIENCING PROBLEMS WITH:

Constitutional: □ fever □ chills □ sweats □ weight loss □ weight gain □ sleepiness □ fatigue

Eyes, Ears, Nose, Mouth, Throat: □ blurry vision □ double vision □ blind spots □ trouble chewing □ choking □ dry mouth

Cardiovascular: □ palpitations □ chest pain □ fainting

Respiratory: □ wheezing □ coughing □ shortness of breath

Gastrointestinal: □ heartburn □ nausea □ vomiting □ constipation □ diarrhea

Genitourinary: □ incontinence □ frequency □ hesitancy □ painful urination □ blood in urine

Neurological: □ numbness □ tingling □ balance difficulties □ spasms □ burning

Musculoskeletal: □ global weakness or myalgia □ focal weakness □ joint pain and swelling □ neck pain □ back pain

Psychiatric: □ anxiety □ depression □ suicidal thoughts or attempts □ insomnia □ memory issues

Endocrine: □ excessive thirst □ hair loss □ sexual problems

Integumentary: □ skin rashes □ eczema

Patient Signature:_____ Date:_____