**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 |
|---|---|---|---|
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| | | | |

**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:_____