VCOR ORTHOPAEDIC PAIN & MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE OF EXAM: _____

DATE OF BIRTH: _____ DATE OF INJURY: _____

1) Please describe how your injury occurred. _____

_____

_____

_____

2) Employer where you were injured: _____

Occupation: _____ Number of years worked there: _____

3) Are you currently employed: Yes No If so, how many hours per week?_____

Occupation: _____ When did you start this job/schedule: _____

4) Has your injury had any effect on your job? If yes, please explain. _____

_____

_____

5) Have you had to change jobs because of your injury? Yes No

6) When/where were your first symptoms from this injury? _____

7) When was your last attack of symptoms? What were you doing at the time?

_____

_____

8) Did it come on gradually or suddenly? (circle one)

9) Was there an associated injury or accident? Yes No (If yes, describe briefly)_____

_____

_____

10) Do you walk normally? _____

About how far can you walk without increased pain? < 1 block 1-2 blocks 2-5 blocks

11) If you have pain after walking, what do you do to relieve it? (circle one) stop and stand; stop and sit; stop, sit and lean forward; lie down.

12) Is your leg or ankle weak? Yes No

13) Does your spine hurt when you bend forward? Yes No

14) Does your spine hurt when you bend backward? Yes No

15) Have you ever had a previous work-related injuries or orthopedic injuries to the cervical spine, thoracic spine, lumbar spine, upper extremity (shoulder elbow or wrist) or lower extremity (hip, knee and ankle)? Yes No If yes, please explain and when did it occur?

_____

_____

16) Have you ever had pain in your joints prior to this injury? Yes No If yes, where?_____

_____

17) Any problems with bladder (urine) control? Yes No

18) Any problems with bowel control? Yes No

19) Does your injury interfere with your sex life? Yes No

20) Are you still able to do activities/chores at home? Yes No

If not, who helps you? _____

PREVIOUS TREATMENTS FOR THIS INJURY

1) Have you received any physical therapy? Yes No (Dates)_____

Did physical therapy improve your symptoms?_____

2) Have you received chiropractic manipulations? Yes No (Dates) _____

Did chiropractic care improve your symptoms? _____

3) What diagnostic tests have you had done for this injury?

X-rays	Yes _____	No _____	Date _____
MRI	Yes _____	No _____	Date _____
CT scan	Yes _____	No _____	Date _____
CT w/dye	Yes _____	No _____	Date _____
EMG/NCS	Yes _____	No _____	Date _____
Discogram	Yes _____	No _____	Date _____
RFA	Yes _____	No _____	Date _____
Injections	Yes _____	No _____	Date _____

4) What surgery(ies) have you had for your condition? _____

_____

_____

PAIN

1) Please circle the number that describes how much pain you feel as a result of your injury:

1 2 3 4 5 6 7

(no pain) (Moderate pain) (Severe pain)

2) Please circle the following activities that make the pain worse: Coughing, Standing, Walking, Running, Sneezing, Driving a car, Riding in a plane, Strain with bowel movements, Sitting, Lying down, Lifting, Putting on shoes, Other (please specify) _____

_____

3) Please circle any of the following that relieves pain: Rest, Heat, Ice, Tens, Manipulation, Massage, Exercise, Brace/Corset, Drugs/Medication, Other (please specify) _____

_____

4) Do you have pain every day? Yes No

5) Is the pain constant during the entire day? Yes No If no, how long does the pain last?

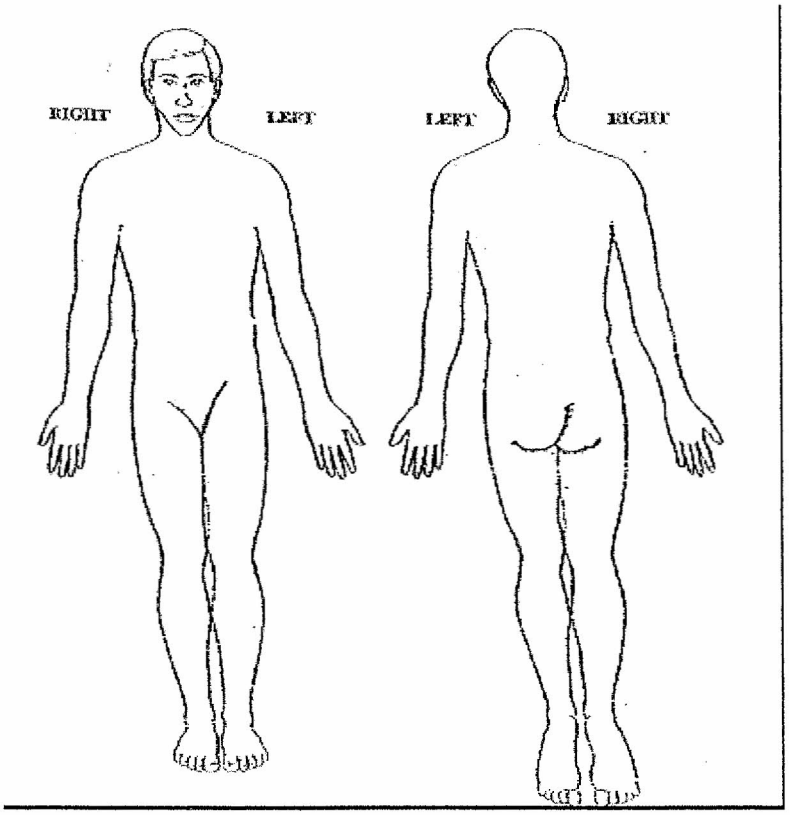
_____

6) Has the pain prevented you from doing your work or going to school? Yes No

If yes, for how long?_____

7) Please indicate on the drawing below the location of your pain using the following symbols/letters:

Aching (AAA) Numbness (═══) Pins & Needles (OOO) Burning (XXX) Stabbing (///)



MEDICAL HISTORY

HEIGHT:_____ WEIGHT:_____

Do you smoke cigarettes, a pipe, or cigars? Yes No How many per day:_____

How much alcohol do you drink? _____ How much caffeine?_____

Marital Status: _____ # of children (ages)_____

List any allergies or bad reactions to medications:_____

List all medications you are currently taking: _____

_____

List all surgeries you have had and the year in which they were done:_____

_____

_____

_____

Please circle all of the illnesses below that apply: Anemia, Arthritis, Asthma, Bleeding problems, Cancer, Circulatory problems / History of blood clots, Dermatitis, Diabetes, Epilepsy, Headache, Heart disease, Hepatitis, Hypertension (high blood pressure), Infection, Kidney disease, Lung disease (breathing disorders), Thyroid problems, Seizures.

List any other significant illnesses/medical history: _____

_____

_____

_____

Family history of medical conditions: _____

_____

_____

_____

Is there anything else that you feel it is important to tell us?

_____

_____

_____

_____

_____

_____