

SPINE & NEURO C E N T E R

MEDICAL QUESTIONNAIRE

This information is confidential. Please fill out this sheet providing as much reliable data as possible.

Name _____ Date _____

Major problem _____

When did you first notice the pain for which you are coming? _____

Are there any warning signs that the pain is coming? YES NO (circle one)

Describe _____

Where does the pain start? _____ Where does it spread from there? _____

How often does it appear? _____ Time of day? _____

How long does the pain last? _____

Type of pain? (Circle all that apply)

pressure throbbing tension sharp burning
dull ache stabbing boring drawing excruciating

Are there any areas of tenderness? YES NO Please describe where _____

Do you have any other signs during the time you have the pain? (vomiting, eye trouble, numbness, tingling, weakness?) Describe _____

Have you had similar pain before? _____ If so, when? _____

Did your pain follow a recent accident or injury? YES NO Date of accident _____

How long after the accident or injury did it appear? _____

Describe this accident or injury _____

Name ALL doctors and chiropractors who have treated you for this _____

*Have you had any of the following studies (CIRCLE ALL THAT APPLY)

XRAY - CT SCANS - MRI SCANS When & where _____

EEG - EMG - nerve conduction studies - doppler studies - arteriogram

When & where _____