Pain/Numbness Questionnaire

Name: _____ Email:_____Phone:_____Date:____/____/____
Address: _____ City:_____ ST_____ Zip_____
Date of Birth _____/_____/_____ Age: _____ Height:_____ Weight: _____
Primary Care Physician: _____ Referring Physician_____
How did you hear about us? _____

Education:
____ High School _____Advanced Degree/Vocational Degree ____College Graduate

Marital Status:
_____Single _____Married(How Long)_____ _____Divorced _____Widowed
Number of Children:_____
If married, please give spouse's occupation_____

Current Occupation or Last Job: _____
Current Employment Status:
_____Full Time _____Part Time _____Unemployed
____Homemaker _____Retired _____Student

Are you receiving compensation or disability payments now? _____Yes _____No
If yes, are payments adequate? _____Yes _____No
Do you have an application for compensation or disability payments pending?___Y ____N

Is your pain or numbness the result of an accident? _____Yes _____No
If yes, where did it occur? Circle one: Home Work Vacation Car Other
(Describe)_____

Pain / Numbness / Neuropathy Information:

What is the main problem for which you are seeking treatment at Lighthouse Health?
_____

Please describe the location of your pain or numbness:_____
_____

How long have you had your current pain or numbness
problem:_____
_____

How did your current pain or numbness start? Was there a precipitating
event?_____
_____

How do the following affect your pain, numbness or tingling? (please circle one for each item)

Lying Down	Decrease	No Effect	Increase
Standing	Decrease	No Effect	Increase
Sitting	Decrease	No Effect	Increase
Walking	Decrease	No Effect	Increase
Exercise	Decrease	No Effect	Increase
Medication	Decrease	No Effect	Increase

Are there other factors that make your pain, numbness or tingling
better?_____
worse?_____

Please rate your pain, numbness or tingling intensity on a scale from 0 (no pain) to 10 (excruciating, incapacitating, worst possible). Rate your pain, numbness or tingling during the past month.

Your pain, numbness at its worst _____
Your pain, numbness at its least _____
Your average pain, numbness_____
Your current pain, numbness _____

How often do you have your pain, numbness or tingling?
_____Constantly (100% of the time) _____Nearly constantly(60-95% of time)
_____Intermittently (30-60% of time) _____Occasionally (less than 30% of time)

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ____Y ____N

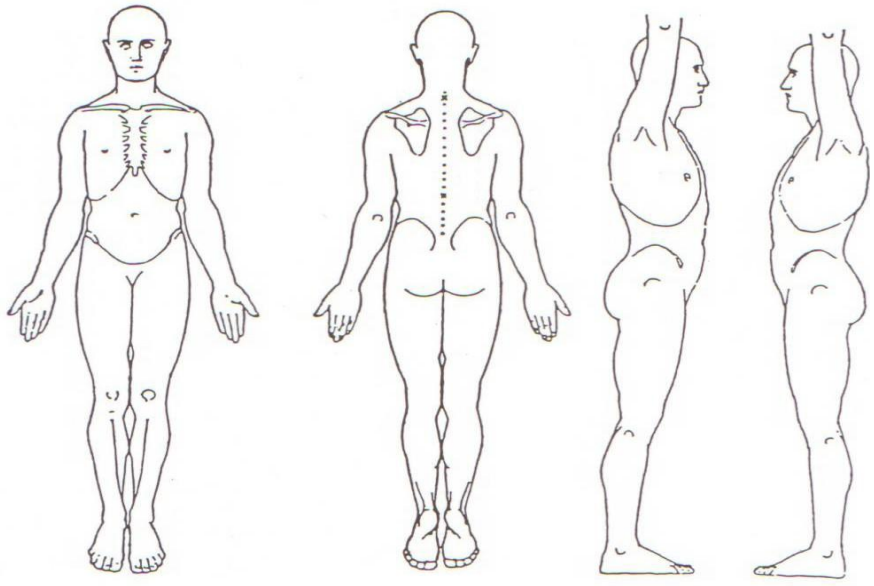
If yes, what and when?_____

Please circle all of the treatments you have tried for your pain, numbness or tingling:

Hospital bed rest	Traction	Surgery	Exercise
Nerve block or injection	TENS(electrical stimulator)		Physical Therapy
Psychotherapy			

Which ones helped you the most? _____
Which ones helped you the least? _____

Have you ever been in treatment for misuse of alcohol or drugs? ____Y ____N
If yes, where and when?_____



Mark the areas that you are experiencing your pain, numbness or tingling. Indicate your pain or numbness type by marking with a letter or letters.

a) deep (inside)
b) Superficial (on the skin)
c) constant (all the time)
d) intermittent (starts and stops)
e) aching
f) burning
g) shooting

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you once you become a patient, and you are personally responsible for payment. This office does not accept insurance of any kind. The services provided are not covered by insurance due to the natural, alternative approach we use here. Your signature also indicates that you authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

Patient Signature_____ Date_____

Office Use Only:_____
_____
_____
_____
_____
_____
_____
History:_____
_____
_____

Date / Visit #					
DTS / Lumbar / Cervical / Supine / Prone					
DTS / Other					
Laser					
ATM					
Ultra Sound					
Oxygen Therapy					
Whole Body Vibe					
Bike					
Sauna					
Leg Wrap					
SMT					