Dr. Lieponis Patient History Questionaire

Please answer each question to the best of your ability.

Name:_____ Age:_____ Occupation:_____

1. When (roughly what date) did your present pain start?

_____

2. How did the pain start? (check appropriate box)

- ❑ Suddenly
- ❑ Gradually
- ❑ Lifting
- ❑ Twisting
- ❑ Fall
- ❑ Bending
- ❑ Pulling
- ❑ Injured at work
- ❑ Injured in auto accident
- ❑ Hit from behind
- ❑ Injured from sports
- ❑ No apparent cause

3. Since it began the pain has gotten:

❑ Better ❑ Worse ❑ Remained Unchanged

4. Typically the pain is likely to occur:

- ❑ Constantly
- ❑ Once a day
- ❑ Once a week
- ❑ Once a month
- ❑ Intermittently
- ❑ Multiple times per day
- ❑ Multiple times per week
- ❑ Multiple times per month

5. Typical episode of pain lasts:

- ❑ Several minutes
- ❑ Several hours
- ❑ Several days
- ❑ Weeks
- ❑ Months
- ❑ Never goes away

6. What activities make the pain worse?

- ❑ Excerise (during)
- ❑ Excerise (after)
- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Bending forward
- ❑ Bending backward
- ❑ Coughing
- ❑ Sneezing

7. What reduces the pain?

- ❑ Lying down
- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Excerises in phyiscal therapy
- ❑ Manipulation
- ❑ Pain Pills
- ❑ Muscle relaxant pills
- ❑ Aspirin or anti-inflamatory pills
- ❑ Injections
- ❑ Nothing
- ❑ Other

8. What other types of doctors or health care providers have you seen for this condition?_____

9. Have you had any of these diagnostic studies?

	Yes	No	Date
X-rays	❑	❑	_____
MRI	❑	❑	_____
CT scan	❑	❑	_____
Discogram	❑	❑	_____
Injections	❑	❑	_____
EMG	❑	❑	_____
Other	❑	❑	_____

10. Have you been hospitalized or had surgery for your pain problem? ❑ Yes ❑ No

Number of times_____Dates_____

_____

_____

11. Have you ever had similar symptoms in the past?

❑ Yes ❑ No Roughly what date_____

Have you had any previous spine injuries?

❑ Work Injury ❑ Motor vehicle accidents ❑ Other

12. Have you been hospitalized for other medical problems?

❑ No ❑ Yes Number of times_____

Describe_____

_____

13. What medications are you currently taking?

_____

_____

14. Do you take antacids? ❑ Yes ❑ No

15. Do you have allergies? ❑ No ❑ Yes

Please list_____

_____

16. Do you smoke? ❑ No ❑ Yes How much?_____

17. Do you drink alcoholic beverages? ❑ No ❑ Yes

How much?_____

18. Do you have any of the following conditions?

- ❑ Weight Loss
- ❑ Heart Problems
- ❑ Respiratory Problems
- ❑ Bowel or Bladder Problems
- ❑ Skin Problems
- ❑ Diabetes
- ❑ Fever or Chills
- ❑ Stomach Problems
- ❑ Arthritis
- ❑ Neurological
- ❑ Ear, Nose, Throat
- ❑ Hematological

19. Are you aware of any family history of medical problems?

Please list:_____

_____

20. List the daily activities which are affected by your pain?

_____

_____

_____

21. Please indicate last grade completed in school_____

_____

22. Have you missed any work because of this problem?

❑ Yes ❑ No List the dates you were unable to work.

From _____to _____

23. To be sure paperwork is filled out correctly, please check if :

- ❑ On workman's compensation
- ❑ Report should be sent to referring physician
- ❑ Receiving disability income
- ❑ Legal proceeding pending
- ❑ Report should be sent to attorney

24. Do you plan to be at your regular job in 6 months?

❑ Yes ❑ No ❑ Unsure

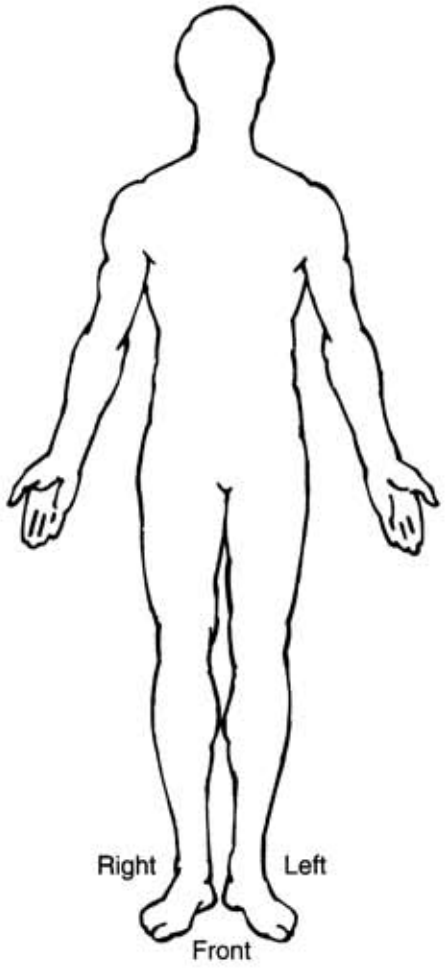
PLEASE COMPLETE THE REVERSE SIDE

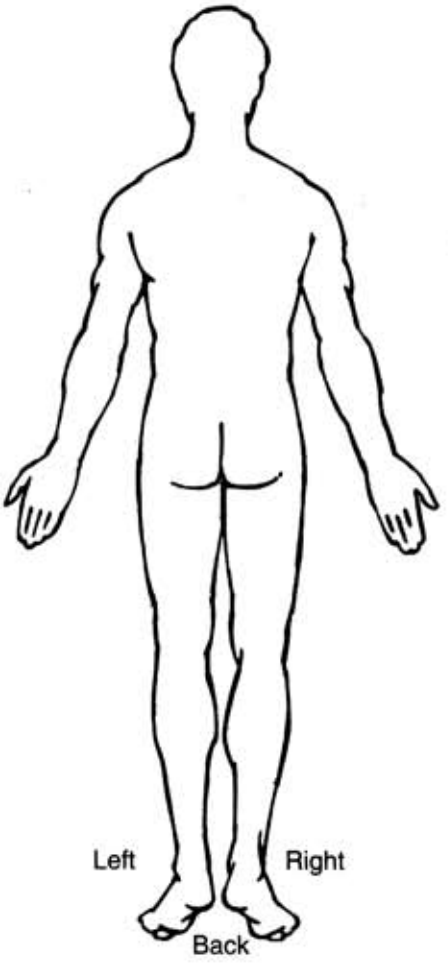
PATIENT PAIN DRAWING

Name_____ Date_____

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲▲▲	= = =	OOO	x x x	/ / /





How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please circle level of pain on the numbers below.

Circle the level of pain

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain