HISTORY QUESTIONNAIRE

GENERAL INFORMATION

Name:_____ Today's Date:_____

Age:_____ Date of birth:_____ Sex: ☐ M ☐ F SS#:_____

Home Address:_____

Cell Phone:_____ Home Phone:_____

Your doctor:_____ Your Attorney (if any):_____

If questions arise after today's interview, is it OK to call you? ☐ yes ☐ no

CURRENT PROBLEM

When did your problem begin?_____How did it begin?

☐ Accident at work
☐ Motor vehicle accident
☐ Other accident
☐ Gradually, due to work activities
☐ Gradually, for no apparent reason
☐ Other_____

Please describe in detail what happened:_____

_____

_____

_____

_____

What symptoms did you have initially?_____

_____

_____

Types of treatment you've had, in order	Response to treatment (for instance: cured the problem, helped for a day or two, no change, made it worse)

Is any further evaluation or treatment planned? ☐ no ☐ yes If yes, what and when?

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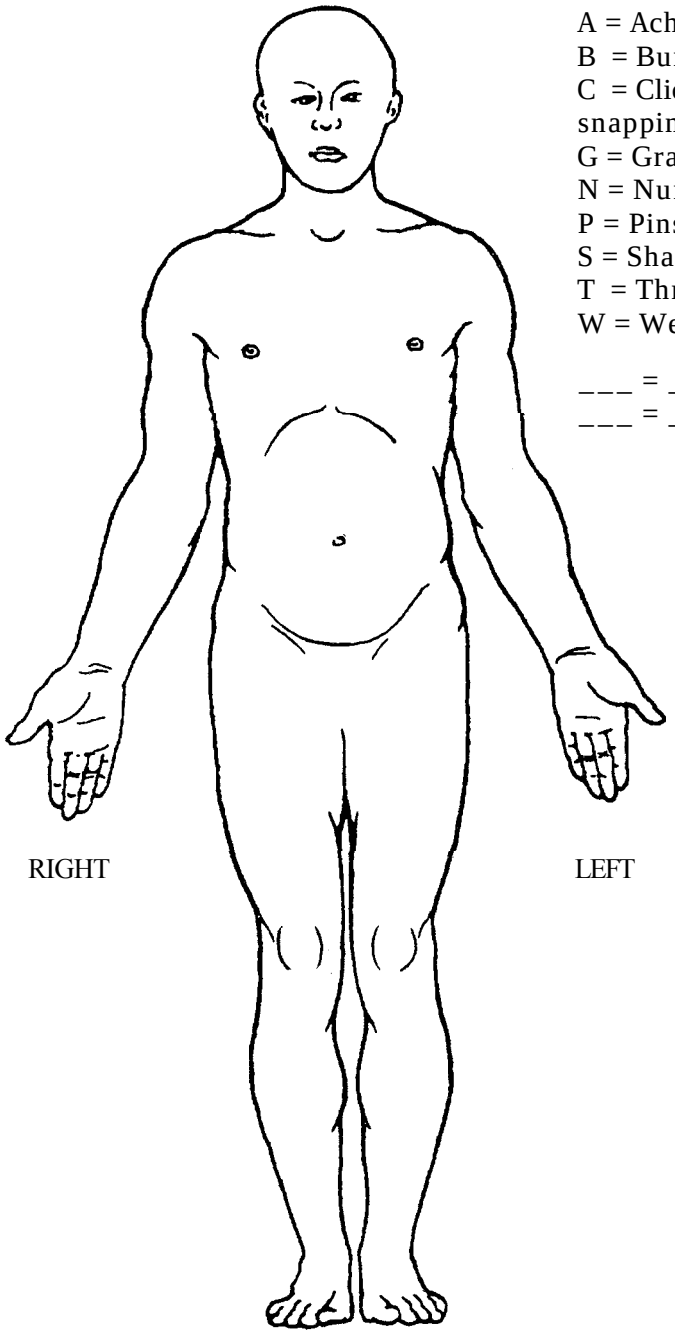
SYMPTOM DRAWING

Please indicate what symptoms you're having now by writing the appropriate letter(s) on the affected body part(s). Feel free to make up your own letter(s) if those below don't adequately describe your symptoms.

FRONT

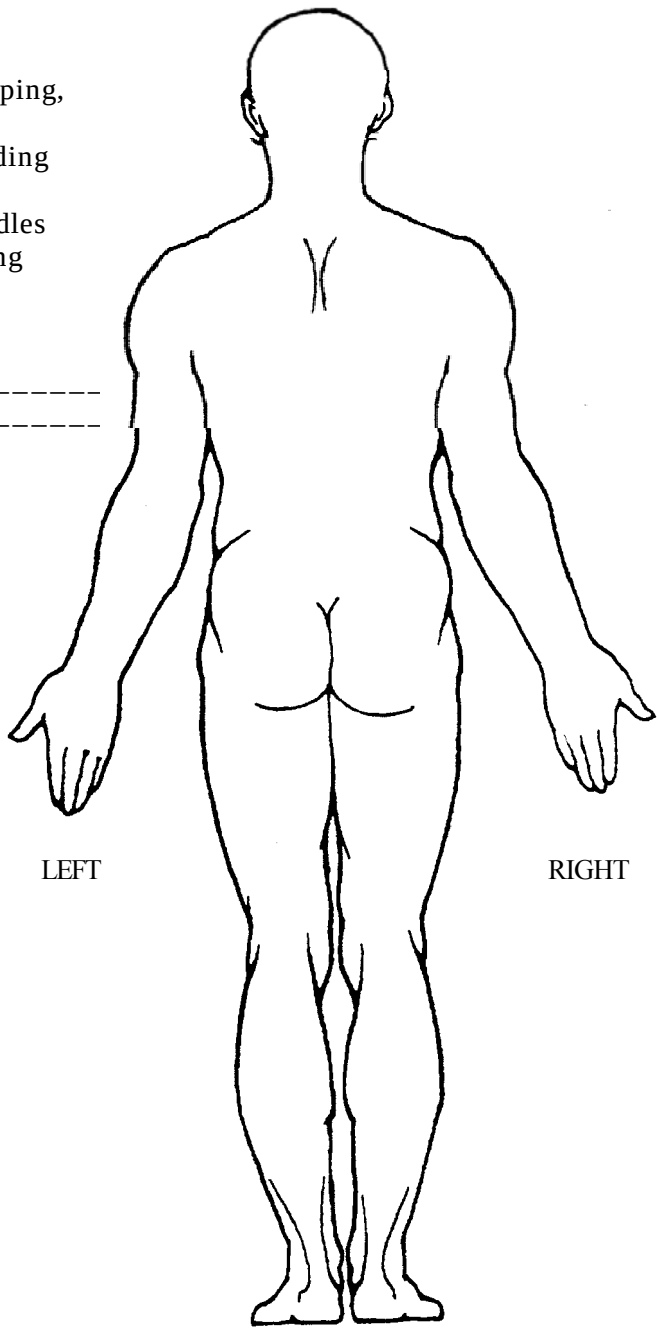


RIGHT LEFT

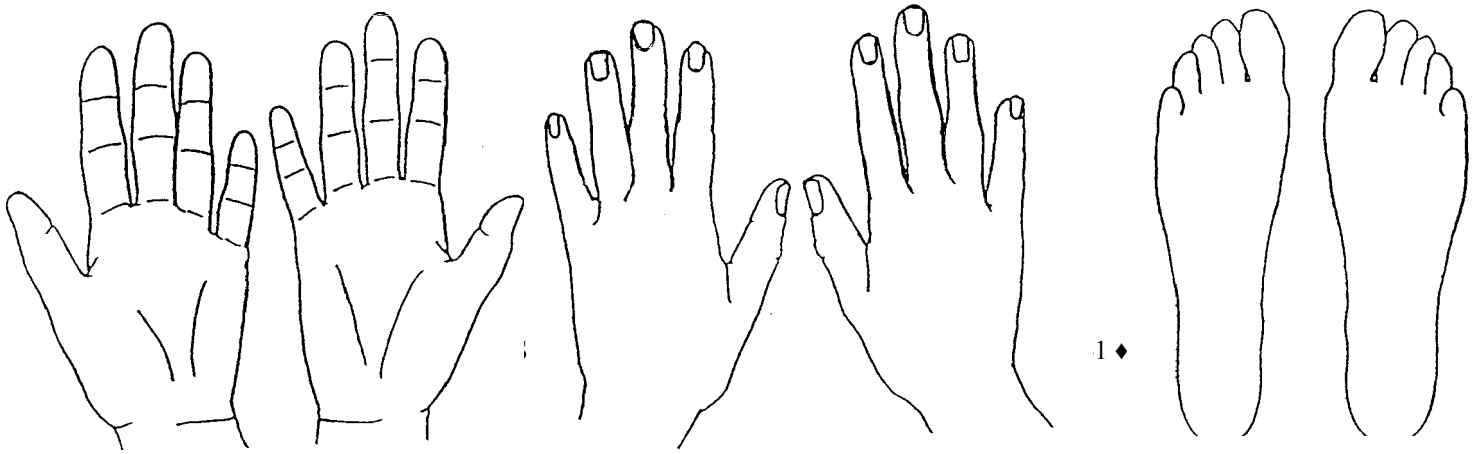
A = Aching
B = Burning
C = Clicking, popping, snapping
G = Grating, grinding
N = Numbness
P = Pins-and-needles
S = Sharp, stabbing
T = Throbbing
W = Weakness

___ = _____
___ = _____

BACK



LEFT RIGHT



CURRENT SYMPTOMS:

Please describe your present symptoms:_____

_____

_____

_____

_____

_____

_____

Please rate any pain(s) on a scale of 0 (no pain) to 10 (the worst pain imaginable):

Location of the pain(s):	_____	_____	_____	_____
Your pain level when problem began:	____	____	____	____
Your current pain level:	____	____	____	____
Average pain level over the past month	____	____	____	____
Lowest " " " " " "	____	____	____	____
Highest " " " " " "	____	____	____	____

Please list each pain or other symptom below. Under frequency write constant if it is always there, or intermittent if it comes and goes. If intermittent, indicate on the second line about how often it occurs, for example, twice a day, once a month, etc. Please also tell us what makes each symptom better (or go away) and what makes it worse (or brings it on).

Symptom	Frequency		
_____	_____	Better:	_____
	_____	Worse:	_____
_____	_____	Better:	_____
	_____	Worse:	_____
_____	_____	Better:	_____
	_____	Worse:	_____
_____	_____	Better:	_____
	_____	Worse:	_____
_____	_____	Better:	_____
	_____	Worse:	_____

Is there one time of day your symptoms are worse? ☐ no ☐ yes, _____

Overall, are you: ☐ getting better ☐ staying the same since ____ ☐ getting worse

What is your greatest concern now?_____

_____

_____

_____

ACTIVITY TOLERANCE

Did you have any limitations before your current problem began? ☐ no ☐ yes
If yes, what were they?

_____

_____

Please describe your typical day:_____

_____

_____

What percentage of your average day is spent sitting or lying down?_____

Are you limited in:			If yes, how long or how much can you:		What limits you?
sitting	☐ no	☐ yes	sit	_____	_____
driving	☐ no	☐ yes	drive	_____	_____
standing	☐ no	☐ yes	stand	_____	_____
walking	☐ no	☐ yes	walk	_____	_____
lifting	☐ no	☐ yes	lift	_____	_____
carrying	☐ no	☐ yes	carry	_____	_____
bending	☐ no	☐ yes	bend	_____	_____
reaching	☐ no	☐ yes	reach	_____	_____
pushing	☐ no	☐ yes	push	_____	_____
pulling	☐ no	☐ yes	pull	_____	_____
climbing	☐ no	☐ yes	climb	_____	_____
squatting	☐ no	☐ yes	squat	_____	_____
kneeling	☐ no	☐ yes	kneel	_____	_____

Are you limited in any other work, home, or recreational activities?

☐ no ☐ yes If yes, please describe:_____

_____

_____

Do you exercise? ☐ no ☐ yes If yes, what do you do and how often?_____

_____

Do you have hobbies? ☐ no ☐ yes If yes, what?_____

_____

Arizona Injury Medical Associates, P.L.L.C.
Physiatry Care

OTHER SYMPTOMS OR CONDITIONS

Please check the first box following the symptom or condition if you've ever had it in the past and check the second box if you're having it now.

	Had in past	Have now
HEAD AND NERVES		
frequent or severe headaches	☐	☐
dizziness or loss of balance	☐	☐
fainting	☐	☐
seizures	☐	☐
stroke	☐	☐
weakness of arms or legs	☐	☐
numbness of arms or legs	☐	☐
shaking or twitching of limbs	☐	☐
EYES		
decreased vision	☐	☐
double vision	☐	☐
dry eyes	☐	☐
eye pain	☐	☐
eye redness	☐	☐
EARS		
decreased hearing	☐	☐
noises in ear(s)	☐	☐
NOSE AND THROAT		
nose bleeds	☐	☐
stuffy nose	☐	☐
frequent sore throat	☐	☐
hoarseness	☐	☐
difficulty swallowing	☐	☐
BREATHING/LUNGS		
frequent cough	☐	☐
frequent colds	☐	☐
allergies or hay fever	☐	☐
asthma	☐	☐
bronchitis	☐	☐
pneumonia	☐	☐
emphysema	☐	☐
shortness of breath	☐	☐
fever	☐	☐
HEART/BLOOD VESSELS		
chest pain	☐	☐
heart disease	☐	☐
high blood pressure	☐	☐
stroke	☐	☐
anemia	☐	☐
blood clots	☐	☐
bruise easily	☐	☐
swelling of ankles and feet	☐	☐
cold sensitivity	☐	☐
STOMACH AND INTESTINES		
heartburn	☐	☐
frequent nausea	☐	☐
vomiting	☐	☐
stomach pain	☐	☐
ulcer	☐	☐
liver problems	☐	☐
gallbladder disease	☐	☐
frequent diarrhea	☐	☐
frequent constipation	☐	☐
hemorrhoids	☐	☐
bloody or tarry stools	☐	☐
loss of bowel control	☐	☐
hernia	☐	☐

	Had in past	Have now
MUSCLES AND BONES	☐	☐
spine abnormality	☐	☐
joint pain, stiffness, or swelling	☐	☐
tendinitis or bursitis	☐	☐
broken bones	☐	☐
muscle wasting	☐	☐
URINARY		
kidney stones or problems	☐	☐
bladder problems	☐	☐
blood in urine	☐	☐
painful urination	☐	☐
frequent urination	☐	☐
difficulty urinating	☐	☐
urinary tract infection	☐	☐
loss of urinary control	☐	☐
FEMALE ORGANS		
breast pain	☐	☐
painful periods	☐	☐
excessive menstrual bleeding	☐	☐
tumors of uterus or ovary	☐	☐
painful intercourse	☐	☐
MALE ORGANS		
abnormality of testicles	☐	☐
abnormalities of penis	☐	☐
erectile difficulty	☐	☐
pain during sex	☐	☐
GLANDS		
diabetes	☐	☐
thyroid problems	☐	☐
SKIN		
rash	☐	☐
other problem	☐	☐
MISCELLANEOUS		
fatigue	☐	☐
fever	☐	☐
loss of appetite	☐	☐
weight gain	☐	☐
weight loss	☐	☐
EMOTIONAL		
physical, sexual, emotional abuse	☐	☐
anxiety	☐	☐
depression	☐	☐
difficulty sleeping	☐	☐
frequent nightmares	☐	☐
feelings of worthlessness	☐	☐
irritability	☐	☐
pressure at work	☐	☐
problems at home	☐	☐
	☐	☐
OTHER PROBLEMS:		
_____	☐	☐

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PAST AND PRESENT BUT UNRELATED MEDICAL HISTORY

Before your current problem began, had you ever had any similar symptoms?
☐ no ☐ yes If yes, please describe:

Please list any prior or subsequent injuries that required treatment: Year:

Please list any illnesses that have required treatment: Year:

Please list any surgeries you've had and their approximate dates: Year:

Please list any overnight hospital stays (except for surgeries) and dates: Year:

WORK HISTORY

Were you employed when your problem began? ☐ No ☐ Yes

If yes: Job title:_____ Employer:_____

How long had you worked there prior to the onset of your problem?_____

In your job how many hours a day did you spend:

sitting_____ driving_____ standing_____ walking_____ other_____

Assuming that: occasionally means up to 1/3 of the time
frequently " 1/3 to 2/3 " " "
constantly " 2/3 to all " " "

Did your job require:	bending	☐ no	☐ yes	☐ occasionally	☐ frequently	☐ constantly
	climbing	☐ no	☐ yes	☐ occasionally	☐ frequently	☐ constantly
	lifting	☐ no	☐ yes	☐ occasionally	☐ frequently	☐ constantly
	twisting	☐ no	☐ yes	☐ occasionally	☐ frequently	☐ constantly
	reaching above shoulder	☐ no	☐ yes	☐ occasionally	☐ frequently	☐ constantly
other activities_____				☐ occasionally	☐ frequently	☐ constantly
_____				☐ occasionally	☐ frequently	☐ constantly

Maximum weight you had to lift or carry _____

Did you miss work as a result of your problem: ☐ no ☐ yes

If yes, how many: _____ days _____weeks _____ months ____ years

Are you working now? ☐ no ☐ yes If no, been off work since_____

Reason(s) not working:_____

Did you enjoy the work? ☐ no ☐ yes Did it pay well? ☐ no ☐ yes

Did you get along well with your supervisor? ☐ no ☐ yes With co-workers? ☐ no ☐ yes

Has your employer treated you fairly? ☐ no ☐ yes Is your job still available? ☐ no ☐ yes

Amount of control you had at work ☐ none ☐ a little ☐ a lot

Amount of stress you had at work ☐ low ☐ medium ☐ high

Are you receiving disability compensation payments? ☐ no ☐ yes If yes:

☐ Workers' comp. ☐ Social Security ☐ Private disability insurance ☐ Other_____

Amount of payments per month $_____ Monthly wages/salary while working $_____

Do you plan to return to work? ☐ no ☐ yes, doing _____ when:_____

Vocational retraining is: ☐ not planned ☐ planned ☐ under way ☐ completed

In what field: _____ Do you have a driver's license? ☐ no ☐ yes

If working: ☐ full time ☐ part time _____ hours per week

☐ same employer ☐ regular work ☐ light duty

☐ new employer Job title:_____

Prior Jobs:

Job Title	Employer	Approximate Dates

FAMILY HISTORY

Do any physical or mental problems run in your family? ☐ no ☐ yes, _____

_____

Is anyone in your family disabled? ☐ no ☐ yes Who?_____

Why?_____

SOCIAL HISTORY

Marital status:

☐ single, never married ☐ married ☐ separated ☐ divorced ☐ widowed

Number of children ____ Number of children dependent on you _____

☐ live alone live with: ☐ spouse _____ children ☐ significant other ☐ friend

Education:

☐ Completed _____th grade ☐ Graduated from high school ☐ Obtained GED

☐ Had _____ year(s) of vocational training in _____

☐ Had _____ years of college but didn't graduate

☐ Graduated from college with ☐ associate ☐ bachelors ☐ masters ☐ doctoral degree in _____

MILITARY HISTORY

Were you in the military? ☐ No ☐ Yes, branch _____

Type of discharge _____ Years of service _____

Any service-connected disability? ☐ No ☐ Yes, _____% for _____

MEDICATIONS AND ALLERGIES

Medications you're taking now	Dosage	When taken
Example: Tylenol	600 mg	3 times a day

Please list the medications you took today prior to your examination?:

_____

_____

Please list medications or other things to which you are allergic:

_____

_____

SUBSTANCE USAGE

Do you smoke? ☐ No ☐ Yes _____ pack(s) per day for _____ years

Do you drink alcohol? ☐ No ☐ Yes What, how much, and for how long? _____

_____

Do you use illegal drugs? ☐ No ☐ Yes What, how much, and for how long? _____

_____

If you answered **no** to any of the above substance usage questions, did you smoke, drink, or use illegal drugs in the past?

☐ No ☐ Yes What, how much, and for how long? _____

Do you use alcohol or unprescribed drugs for pain? ☐ No ☐ Yes

PHYSICAL DATA

☐ Right-handed ☐ Left-handed ☐ Ambidextrous Your height _____ Your weight_____

Has your weight changed since the problem began? ☐ No ☐ Yes, gained_____ lost_____