METROPOLITAN NEUROSURGERY

Patient Questionnaire

Name_____
Date_____

1. Please list your Primary Care Physician and his/her address _____
_____
_____

2. Have you ever treated with a Chiropractor? (circle one) YES NO If yes, list name of chiropractor(s), address and phone number;

_____
_____

3. Have you ever been involved in a motor vehicle accident? (circle one) YES NO If yes, list date of accident(s);

_____

_____

4. What injuries did you sustain, if any, from previous accidents?

_____

_____

5. Have you had any injuries or accidents before or after your current injury? (Circle) YES/ NO

If yes, please describe the injury and set forth the date you were hurt.

_____
_____

6 Please list all the names and locations of all treating Pain Management Providers, past and present.

_____
_____

MRI YES NO if so (circle) Lumbar Cervical

CAT scan YES NO if so list location on body

_____

7. Have you
ever had an MRI or CAT scan of the back and/or neck? (circle all that apply to you)

If yes, list when and which Radiology center(s) _____
_____
_____

8. What is your current employment status? (Circle one) circle more than one if it applies to you

Employed Full-time Employed Part-time Self Employed Homemaker Student Retired

Unemployed due to pain and/or disability For how long? _____

Unemployed due to other reasons For how long? _____

9. What is your present or most recent occupation?___

10. Do you have/had any part-time jobs over the last 5 years? (circle one) YES NO

11. 11. Please list your prior full time and part time employers and job titles for the past 5years:_____
_____

12. Are you receiving compensation or any form of disability benefit for any of your injuries?
_____Yes___No If so please set forth such payments_____
_____

13. Please describe in detail what caused your current condition._____
_____
_____

14. Please list all medical providers and locations that have treated you for this condition

_____

_____

_____

_____

15. Please list all medications you are currently taking:

Medication	Dosage	# Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Please list all your past medications

Medication	Dosage	# Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

17. Please list your allergies and reactions

_____

_____

_____

18. Please list all surgeries

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

19. Age at last birthday:_____Gender: M F

20. Which of the following best describes your current marital status?
___ Single___Married _Widowed____Separated ___Divorced____Never married

21. With whom do you live? (check all that apply)
___ Self ___Spouse/Significant other____Children ___Parents ___Friends ___Others

22. Is your father still living?_____Is your mother still living?___If not, list date and cause(s)

of death _____

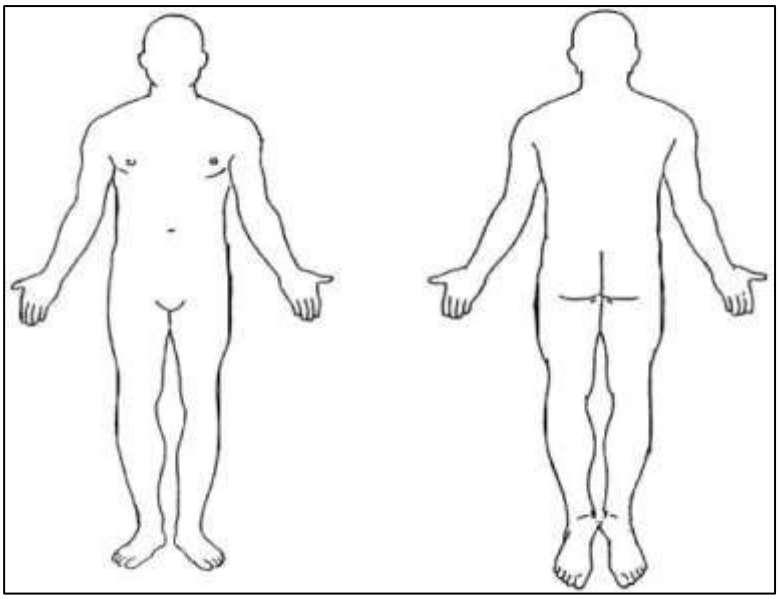
23. Do you have children? _____If so, please provide their names and ages:
_____
_____

24. Do you currently (In the past 12 months) participate in any athletic, recreational or sporting activities? (circle one) YES NO

If yes, list the activities you participate in_____

_____

25. Please shade in the painful areas, put **XXX** on areas of tingling, **000** on burning areas, **+++** on area with no feeling at all.



i. What is the average level of pain you have last two weeks?

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

ii. What is the least severe pain you have had in the last two weeks?

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

27. What is the greatest amount of pain you have had in the last two weeks?

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

28. How much is pain interfering with your activities?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

29. What is your mood like now i.e.: Sad - Happy – Anxious **where 1=worst 10=best**

SAD 1 2 3 4 5 6 7 8 9 10

Happy 1 2 3 4 5 6 7 8 9 10

Anxious 1 2 3 4 5 6 7 8 9 10

NAME_____ Date_____

Signature_____