**Patient Name:**

**DOB:**

**MRN:**

**Clinic Location:**

**Patient Questionnaire**

**Dear Patient:**

**Please complete this questionnaire before you come for your appointment. Be sure to call us as soon as possible if you cannot make your appointment. *Thank you.***

**Your Name**

**Day Phone # Evening Phone #**

**Address**

**City State Zip**

**Date of Birth Age**

**Primary Physician’s Name, Address, and Phone**

**Referring Physician’s Name, Address, and Phone**

**Preferred Pharmacy Phone #**

***QUESTIONS ABOUT YOUR CURRENT PROBLEM:***

**1. When did your pain problem first occur?**

**2. How did it happen? Accident at work Accident at home Following surgery**

 **Please check (!) one: Car accident Other accident**

**3. Have you ever had this pain before? If yes, explain.**

**4. Place an X on each line between 0 and 10 to indicate your level of pain last week:**

**\_\_\_\_\_\_\_\_\_\_\_Worst this week**

**\_\_\_\_\_\_\_\_\_\_\_(no pain) 0 10 (worst possible pain)**

**\_\_\_\_\_\_\_\_\_\_\_Best this week**

**\_\_\_\_\_\_\_\_\_\_ (no pain) 0 10 (worst possible pain)**

**\_\_\_\_\_\_\_\_\_\_Average this week**

**\_\_\_\_\_\_\_\_\_\_ (no pain) 0 10 (worst possible pain)**

**5. What makes your pain worse?**

**6. What makes your pain better?**

**7. Yes No Do you think your pain is caused by something that is different or more serious than what your doctor has told you?**

**8. What do you think is the cause of your pain?**