Geoffrey Tyson, M.D.
6808 220th Street S.W., Suite 201, Mountlake Terrace, Washington 98043
Phone 425-640-6976 Fax 425-640-6977

Health History and Pain Questionnaire

THIS FORM MUST BE RETURNED 10 DAYS BEFORE YOUR APPOINTMENT OR YOUR APPOINTMENT WILL BE AUTOMATICALLY CANCELLED!!

Thank you for completing the following questionnaire. The questions asked and your thorough response is critically important in developing a treatment plan specifically for you.

Name: _____Date:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): (_____)_____ Work: (_____)_____

Cell Phone: _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Current age: _____ Height: _____ Weight: _____ Weight one year ago: _____ Birthdate: _____
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Domestic Partner
How would you describe yourself:

Aleutian Asian Black/African
Middle Eastern White/Caucasian Hispanic/Latino
Other (specify): _____

Hand Dominance: ( ) Right-handed ( ) Left-handed ( ) Ambidextrous

What is your present or most recent occupation: _____

Current Employment/Date last worked: _____

( ) Full time ( ) Part time ( ) Retired
( ) Homemaker ( ) Unemployed due to pain
( ) Unemployed for other reasons (Specify) _____

With whom do you live: _____ Relationship: _____

Do they work outside of the home Y/N If so, employer/occupation: _____

What is the highest grade you completed:

( ) Less than High School ( ) High School ( ) College ( ) Graduate School
( ) Other _____

What are your present sources of financial support: (Check all that apply)

( ) Salary/Employment Income ( ) Savings
( ) Disability ( ) Workers Compensation
( ) Insurance ( ) Other: _____

Workman's Compensation patients please complete the following questions

1. Who is your Primary Treating Physician: _____

2. Are you represented by an attorney: Y/N Name: _____

   Address: _____ Phone: _____

3. Status: Please indicate the date of determination for the following: _____
   ( ) Temporary Total Disabled ( ) Permanent and Stationary
   ( ) Disability Rating _____ ( ) Medically Rated _____
   If you have settled your claim, do you have future medical care: Yes/No

Pain History:

1. What is the problem for which you were referred (Chief complaint):_____.

2. What is the date that your pain began: _____

3. How were you injured/ How did your pain develop:
   ( ) Work related ( ) Auto accident ( ) Accident at home
   ( ) Following an illness ( ) Following surgery ( ) Pain began spontaneously ( ) Lifting
   ( ) Twisting ( ) Falling ( ) Other: _____

   Please describe the onset and circumstances of your pain: _____
   _____

4. Have you changed the type of work or given up your job due to your pain: ( ) Yes ( ) No

5. If unemployed, what is the last date you worked: _____

6. Is there any legal action pending as a result of this problem: ( ) Yes ( ) No If yes, please specify (i.e. auto accident) _____

7. What does your pain fell like: (Circle all that apply)

Pulsing	Throbbing	Pounding	Jumping	Shooting	Pricking	Stabbing	Sharp
Pinching	Gnawing	Cramping	Tugging	Pulling	Hot	Burning	Tingling
Stinging	Dull	Aching	Heavy	Tender	Spreading	Radiating	Numb
Squeezing	Cool	Cold	Nagging	Agonizing	Tiring	Exhausting	Sickening
Suffocating							

   Other: _____

8. What kinds of feelings accompany your pain: (Circle all that apply)

Fearful	Frightened	Terrified	Punished	Anger	Guilt	Depressed
Anxiety	Frustration					

9. How often does your pain occur: (choose one) ( ) Continuously ( ) Several times a day ( ) Once a day ( ) Several times a week ( ) Several times a month ( ) Once a month ( ) Less frequent that once a month ( ) Never ( ) Other

10. How often does your pain **interfere** with your activities: ( ) Continuously ( ) Several times a day ( ) Once a day ( ) Several times a week ( ) Several times a month ( ) Once a month ( ) Less frequent that once a month ( ) Never

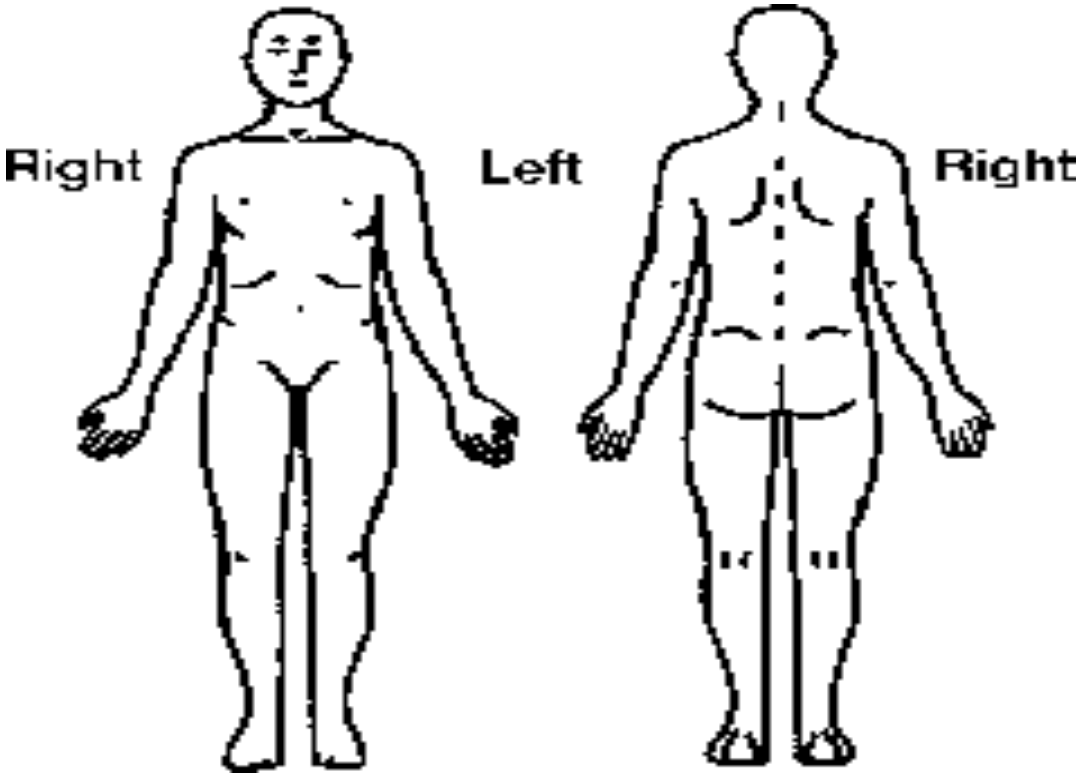
11. Is your pain: (choose one) ( ) Getting better ( ) Getting worse ( ) Staying the same

12. Choose **one** word group that best describes your pain pattern: ( ) Continuously, steady, constant ( ) Rhythmic, periodic, intermittent ( ) Brief, momentary, transient

13. What makes your pain worse: _____

14. What makes your pain better: _____

15. Mark the location of your pain:



16. Review the statements indicating and describing the area of your pain:

	Yes	No
Extreme sensitivity to touch		
Weakness		
Decreased sensation		
Joint tenderness and stiffness		
Decreased range of motion		
Swelling or edema		

17. We are interested in two main aspects of your pain experience: The intensity of the pain and how strong it is as well as how disturbing or bothersome the pain is. Please indicate the **range** (lowest and highest) on each scale:

Pain Intensity

Low "0" _____ "10" High

Pain Disturbing

Low "0" _____ "10" High

18. In general, how likely do you fell that your pain will be removed or cured: (Circle one)
Impossible Unlikely Uncertain Likely Certain

19. If the worst pain you ever experienced is a TEN and no pain is ZERO, what is your **current** pain level: _____

20. If it is not possible to completely alleviate your pain, what would be an acceptable level of pain on a scale of ZERO to TEN: _____

21. If your pain were reduced to an "acceptable level" for you, list the kinds of activities you would engage in that your current pain level prevents you from doing: (Be specific)

_____

_____

22. How many times this year have you been to the emergency room because of a pain problem: ____
Please describe: _____

23. How many times this year have you been admitted to a hospital for any problem associated with pain: _____

24. Has anyone in your family ever had a chronic pain problem: Y/N If yes, please describe: _____
_____

25. Most people have seen one or more other doctors or other practioners before coming to our office. **Please indicate any practioners you have seen and list the names and telephone numbers below of any who have prescribed pain medicine for you in the last 3 years (Including Emergency Room visits):**

( ) Acupuncture	( ) Anesthesiologist	( ) Bio Feedback	( ) Chiropractor
( ) General Practice	( ) Hypnotist	( ) Herbologist	( ) Internal Medicine
( ) Massage Therapist	( ) Naturopath	( ) Neurologist	( ) Neurosurgeon
( ) Nutritionist	( ) Osteopath	( ) Orthopedist	( ) Podiatrist
( ) Physical Therapy	( ) Psychiatrist	( ) Psychologist	( ) Surgeon

_____
_____
_____
_____
_____

Past Medical History:

1. Are you otherwise in good health: Y/N If yes, please describe: _____
   _____
2. When was your last routine physical exam: _____ By whom: _____

   If applicable: Last Pap smear: _____ Mammogram (or exam): _____
3. Have you ever been diagnosed with any form of Hepatitis? Y/N If yes, describe: _____
4. Do you currently have or ever had (Include the approximate year of diagnosis)

Condition	**Yes**	**No**	**Describe**
Heart Disease	( )	( )	_____
Lung Disease	( )	( )	_____
Kidney Disease	( )	( )	_____
Liver Disease	( )	( )	_____
Thyroid Disease	( )	( )	_____
High Blood Pressure	( )	( )	_____
Bleeding Tendencies	( )	( )	_____
Anemia	( )	( )	_____
Stroke	( )	( )	_____
Cancer	( )	( )	_____
Seizures	( )	( )	_____
Diabetes	( )	( )	_____
Arthritis	( )	( )	_____
Ulcers	( )	( )	_____
Emotional Problems	( )	( )	_____
Other	( )	( )	

4. Hospitalizations/Operations: Please list any previous hospitalizations/operations.

   Hospitalization Year Complications

   _____
   _____
   _____

   Operation Year Complications

   _____
   _____
   _____

5. Please list and describe any past or current serious illnesses or injuries not already covered: _____
   _____
   _____

6. Have you had any problems with surgery/anesthesia in the past: _____

7. Do you have any allergies to medicines: _____

8. Does any medicine make you sick: _____

9. Describe your reaction: _____

Present Medications

Please list **ALL** the medications you are currently taking for your pain, dose and frequency. Include all medications including aspirin, lotions, skin patches, etc.

Medication Name	Dose and Frequency	Degree of Relief and Side Effects

Past Pain Medications

Medication Name	When Taken/How Long Ago	Why Stopped

Personal Habits

1. Do you use Tobacco: Type _____ Amount/Day _____ # of Years _____
   If not currently, how much in the past: _____
2. Do you use Alcohol: Type _____ Amount/Day _____ # of Years _____
   If not currently, how much in the past: _____
3. Do you use Marijuana: Type _____ Amount/Day _____ # of Years _____
   If not currently, how much in the past: _____
4. Do you use recreational drugs: Type _____ Amount/Day _____ # of Years _____
   If not currently, how much in the past: _____
5. Are you currently or have you been involved in a drug or alcohol rehabilitation program including twelve steps programs: ( ) Yes ( ) No If yes, please describe: _____
   (All responses will be kept confidential)
6. Are you on a special diet: ( ) Yes ( ) No Please describe _____
7. Do you exercise on a regular basis: ( ) Yes ( ) No Please describe _____

Family History

Family Member	Living		Age	Major Medical Problems or Cause of Death
	Yes	No		
Father				
Mother				
Siblings				
Children				

Review of Systems
(Circle all that apply)

Eyes:	Blurred vision	Pain		
Nose:	Nose Bleeds	Nasal congestion	Runny nose	
Throat:	Sore throat	Difficulty swallowing	Hoarseness	Burning in back of throat
Oropharynx:	Dentures Full / Partial			
Heart:	Chest Pain Congestive heart failure last six months	Previous heart attack	Dizzy spells	
Lungs:	Wheezing	Short of breath	Smoke	Asthma environmental allergies
GI:	Indigestion Jaundice	Abdominal pain Rectal bleeding	Nausea/Vomiting Incontinence	Dark Stools Change in bowel function
GU:	Pain with urination Frequent urination at night	Frequent urination	Blood in urine	Incontinence
Musculoskeletal:	Swelling in joints Neck problems	Restricted movement Lower back problems	Pain in muscles	Pain in joints
Skin:	Rashes	Lesions	Change in hair or nails	
Neurological:	Seizures	Loss of consciousness	Paralysis	Tremor Weakness
Psychiatric:	Depression	Suicide attempts/plans	Anxiety disorder	
Endocrine:	Diabetes	Thyroid disorder		

Hematology/Lymphatic: Anemia Abnormal bleeding Excessive bruising Enlarged lymph nodes
Previous blood transfusion Pitting edema