Wellness Questionnaire

Patient's Name _____ Date

History: ☐ Lower Back ☐ Upper Back ☐ Neck Pain ☐ Headaches
☐ Mid Back ☐ Between Shoulder Blades ☐ Other _____

The Intensity is:
<NO PAIN> 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 <DEATH>

My pain began: ☐ Gradually ☐ Suddenly **Pain is**: ☐ Constant 100% ☐ Frequent 75% ☐ Occasional 50% ☐ Intermittent 25%
How did the pain first begin? (upon waking, bending, falling, if falling what broke the fall first)

_____
_____
_____
_____
_____

Symptoms first appeared: ☐ Immediately ☐ Hours after the accident ☐ The next day ☐ Days later (# of Days _____)
Did you have any cuts from the injury? ☐ Y ☐ N **Bruises?** ☐ Y ☐ N
If Yes, where? _____
The sensation is:
☐ Shooting ☐ Aching ☐ Burning ☐ Stiffness ☐ Stabbing ☐ Numbness
☐ Dull ☐ Sharp ☐ Throbbing ☐ Cramping ☐ Pins & Needles ☐ Other_____

Pain goes into: ☐ Left Leg ☐ Left Arm ☐ Back of head **Type of pain:** ☐ Shooting ☐ Numbing ☐ Pins & Needles
☐ Right Leg ☐ Right Arm ☐ Stays in one place ☐ Stabbing ☐ Aching ☐ Other _____

Condition is getting: ☐ Better ☐ Worse ☐ Staying about the same

Pain has woken you up during the night: ☐ Y ☐ N **Weather changes affect pain:** ☐ Y ☐ N

What treatment have you tried? _____
What home remedies are you doing for the pain? _____
Does anything make the pain feel better? _____

Are there other variables you feel are important regarding the pain? (current weight, stress, diet, smoking, other health issues)

_____
_____
_____
_____

Have you returned to work since the injury? ☐ Y ☐ N If yes, how affected? _____
My pain is worse when I: ☐ Cough ☐ Sit ☐ Walk ☐ Push ☐ Stand for long periods ☐ First wake up
☐ Sneeze ☐ Bend ☐ Lift ☐ Pull ☐ Lie down ☐ Getting up/Down

Has pain affected your daily living in any way?
☐ Working ☐ Bending over ☐ Playing with kids ☐ Using Bathroom
☐ Sleeping ☐ Reaching over head ☐ Driving ☐ Cooking
☐ Sitting ☐ Cleaning house ☐ Exercising ☐ Standing
☐ Walking ☐ Brushing teeth ☐ Shopping ☐ Lifting

Does anything else make the pain worse? _____