DISC Patient Questionnaire

Please complete and bring with you to your appt on:_______________________ At:__________

**** If your X-rays or MRI were not done at Derry Imaging please bring disc.***

Part A: General Information

Name: ______________________ Date of Birth________ Age_____ Height_______ Weight_______

Primary Care Physician: ____

Referring Physician: ____

Do you have a support system? ☐ Yes ☐ No

Are you presently involved in a lawsuit? ☐ Yes ☐ No

Is your pain the result of an accident? If yes, please describe briefly.

____

Part B: General Medical Information

Past Medical History: (check all that apply)

☐ Angina ☐ Arthritis ☐ Anxiety/Depressions ☐ Bladder/Kidney Problems

☐ Blood Clots/Bleeding Disorders ☐ Cancer ☐ COPD/Asthma

☐ CHF I Heart Failure ☐ Diabetes/ Thyroid ☐ Pacemaker

☐ Prostate Problems ☐ Reflex/Hiatal Hernia/Ulcer ☐ Seizures/Epilepsy

☐ Sexually Transmitted Disease ☐ Stroke/TIA ☐ Sleep Apnea/CPAP

☐ Visions/Hearing Problems ☐ Other ___________________________________

Past Surgical History, as related to your pain:

____

Medications with Dosage and Frequency (including over-the-counter medications)

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Allergies to medication (with reaction)

____
____
____

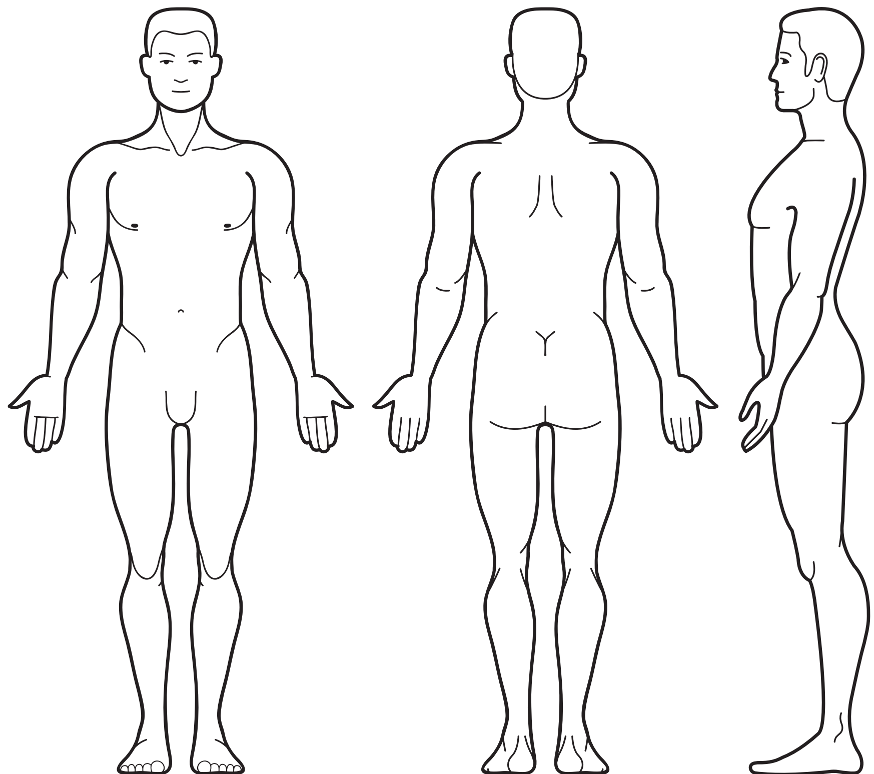
Are you on blood thinners? ☐ Yes ☐ No

Do you have a pacemaker/defibrillator? ☐ Yes ☐ No

Are you safe at home? ☐ Yes ☐ No

Part C: Pain History

Mark the location(s) of your pain with an "x" on the diagram. If whole areas are painful, shade in the painful area



Describe your pain: ____________________

____
____
____
____

☐ Deep (inside)

☐ Superficial (on the skin)

☐ Aching	☐ Burning	☐ Shooting
☐ Stabbing	☐ Tingling	☐ Numb
☐ Weak	☐ Throbbing	☐ Other

Have you experienced any falls in the past 3 months? ☐ Yes ☐ No

Previous treatments tried for your pain:
(check all that apply. If helpful indicate by writing "yes" after the check box)

☐ **Physical therapy (for how long?)** ☐ Nerve Block or injection

☐ Massage ☐ Home exercise & Stretching program ☐ Acupuncture

☐ Psychotherapy ☐ Chiropractic ☐ NSAIDS ☐ Muscle Relaxants

☐ Steroids ☐ Narcotics

Have you been to another Pain Center for injection or medication therapy? (Briefly describe)

____

____

____

____

Where's your pain? ☐ Back ☐ Neck ☐ Other ______________________________

How long have you had your current pain problem (in years and/or months?)

____

How did your current pain start? Was there a precipitating event?

____

Rate your pain intensity on a scale from 0 to 10 with 0 =no pain / 10 = excruciating, incapacitating worst pain possible. Rate your pain during the past month or so since your injury. Circle the number for each question below.

Your pain at its worst	0	1	2	3	4	5	6	7	8	9	10
Your pain at its least	0	1	2	3	4	5	6	7	8	9	10
Your average pain	0	1	2	3	4	5	6	7	8	9	10

Do you presently smoke cigarettes or use tobacco in any form? ☐ Yes ☐ No

If not, did you ever smoke cigarettes or use tobacco in any form? ☐ Yes ☐ No

How many packs do (did) you smoke a day? ____________________

For how many years? __________