



The following information is required for your case history file

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
(Mr. Mrs. Ms.) First / Middle / Last

Spouse's Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City Zip

Social Security No: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / If Military, Serial: \_\_\_\_\_

Patient Employed by: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street City Zip

Patient's Occupation: \_\_\_\_\_ Bus. Phone: (\_\_\_\_) \_\_\_\_\_

Spouse Employed by: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street City Zip

Spouse's Occupation: \_\_\_\_\_ Bus. Phone: (\_\_\_\_) \_\_\_\_\_  
Area Phone

Patient's Group Health Insurance: \_\_\_\_\_  
(Group and Membership Numbers)

Recommended by: \_\_\_\_\_ Physician: \_\_\_\_\_

For minor patients, list legal guardian: \_\_\_\_\_

In an emergency, we should contact: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Area Phone

## Pain Evaluation Questionnaire

Name: \_\_\_\_\_ Date \_\_\_\_\_ Age: \_\_\_\_\_

Please complete the following questions. Answer as accurately as you can. This information is confidential and will help us properly diagnose and treat your pain issues.

Where is your pain? \_\_\_\_\_  
\_\_\_\_\_

When did it begin? \_\_\_\_\_ Was it gradual \_\_\_\_\_ or sudden \_\_\_\_\_

Did it begin at home \_\_\_\_\_ at work \_\_\_\_\_ following an illness \_\_\_\_\_

Related to an accident \_\_\_\_\_ related to employment \_\_\_\_\_ it just "came on" \_\_\_\_\_

Related to surgery \_\_\_\_\_ or other (please explain) \_\_\_\_\_

Does the pain spread? \_\_\_\_\_ Where? \_\_\_\_\_

Underline the words that best describe the pattern of your pain. The pain is:

1. Continuous, Steady, Constant
2. Rhythmic, Periodic, Intermittent
3. Brief, Momentary, Transient

How strong is your pain? Circle one:

1. Mild
2. Uncomfortable
3. Distressing
4. Horrible
5. Excruciating

Which word (from the list above) describes your pain **right now**? \_\_\_\_\_

Which word describes your pain at its worst? \_\_\_\_\_

Which word describes your pain at its least? \_\_\_\_\_

What makes your pain worse or increases it? \_\_\_\_\_

What relieves your pain? \_\_\_\_\_

How long have you been unable to work? \_\_\_\_\_

How long have you been unable to engage in normal activities? \_\_\_\_\_

Put an X in the box next to any activity that increases or aggravates your pain:

Pushing	Pulling	Lifting	Bending	Turning
Twisting	Reading	Walking	Squatting	Sitting
Standing	Sports	Worry	Lying down	Coughing
Sneezing	Stress	Depression	Sexual intercourse	Damp or cold weather

Other (please explain): \_\_\_\_\_

List all treatments you've had for your pain. Please include the names of doctors, therapists, and the dates and types of procedures (if known).

Medical Treatments: \_\_\_\_\_

\_\_\_\_\_

Therapy (for example, physiotherapy, radiation, chemotherapy, etc.): \_\_\_\_\_

\_\_\_\_\_

Surgery (related to pain): \_\_\_\_\_

\_\_\_\_\_

Pain Medication (please include dosage and frequency taken):

Taken in the past: \_\_\_\_\_

Taking now: \_\_\_\_\_

Other treatment I've had for pain: \_\_\_\_\_

Have you had any adverse drug reactions? For example, allergic reactions, overdoses, intestinal upsets, dizziness, vomiting, and other problems? Please list the drug and the reaction you experienced.

\_\_\_\_\_

\_\_\_\_\_

### Personal Habits

Do you smoke? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ How many ounces per day? \_\_\_\_\_

## Pain Body Map

Please indicate where your pain is on the drawings below. If the pain begins in one area and travels to another, draw in arrows that point in the correct direction of the travelling pain. Use the numbers below to indicate the quality of your pain.

**1. Burning**

**2. Sharp**

**3. Aching**

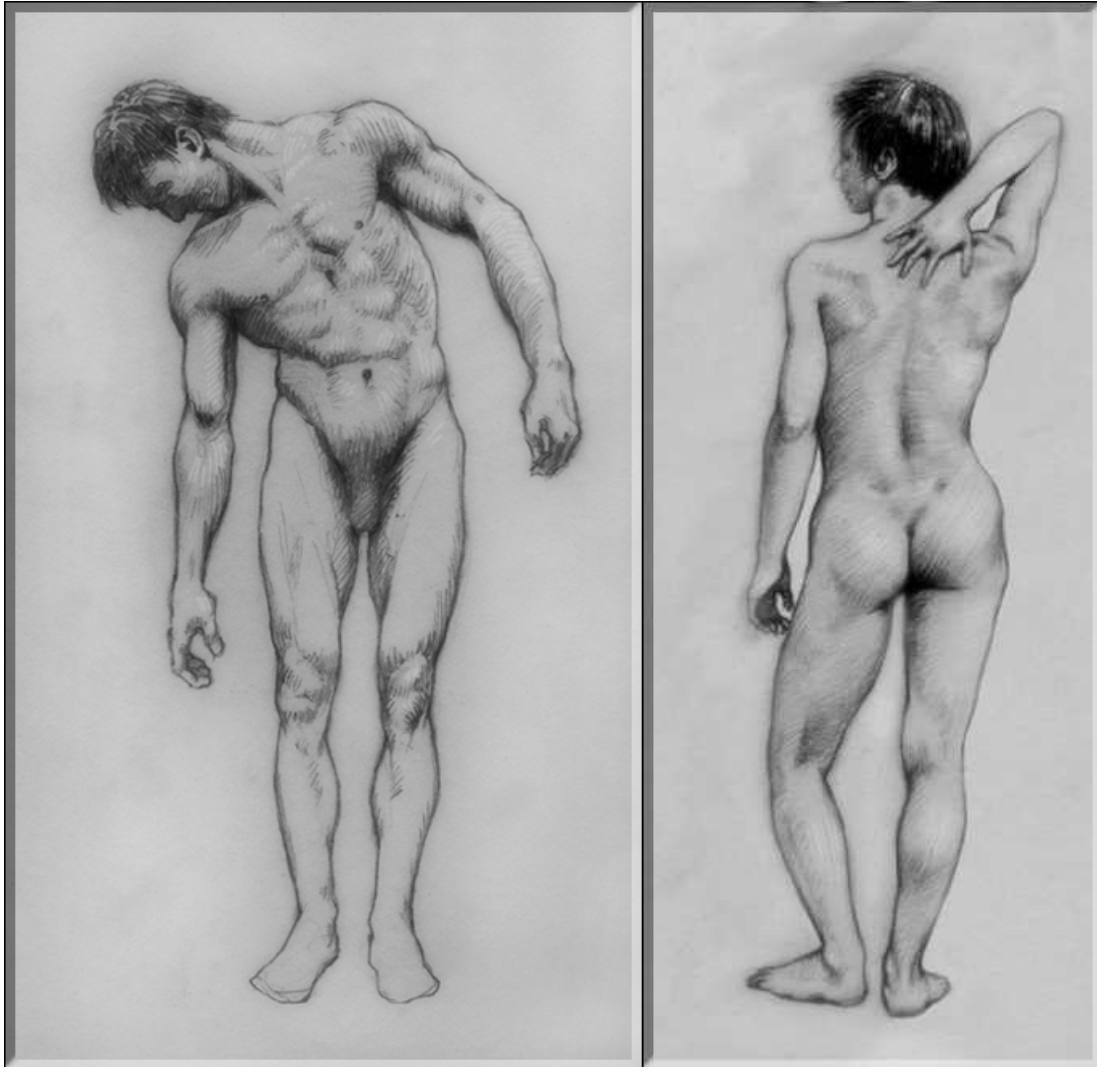
**4. Radiating**

**5. Nagging**

**6. Cramping**

**7. Throbbing**

**8. Tingling**



## Pain Descriptions

What does your pain feel like? Pick some of the words below to describe your *present pain*. Circle **only** those words that best describe it. **Leave out** any category that's not suitable to how you feel right now. Use only a **single** word in each appropriate category. Pick only the word that applies best.

1. Flickering Quivering Pulsing Throbbing Beating	6. Tugging Pulling Wrenching	11. Tiring Exhausting	16. Annoying Troublesome Miserable Intense Unbearable
2. Jumping Flashing Shooting	7. Hot Burning Scalding	12. Sickening Suffocating	17. Spreading Radiating Penetrating Piercing
3. Pricking Boring Drilling Stabbing Lancinating	8. Tingling Itching Smarting Stinging	13. Fearful Frightful Terrifying	18. Tight Numb Drawing Tearing
4. Sharp Cutting Lacerating	9. Dull Sore Hurting Aching Heavy	14. Punishing Grueling Cruel Vicious Killing	19. Cool Cold Freezing
5. Pinching Pressing Gnawing Cramping Crushing	10. Tender Taut Rasping Splitting	15. Wretched Blinding	20. Nagging Nauseating Agonizing Dreadful Torturing

Please don't mark in this section.

PRI: S \_\_\_\_\_ A \_\_\_\_\_ E \_\_\_\_\_ M \_\_\_\_\_  
           (1-10)       (11-15)       (16)       (17-20)

PRI: T \_\_\_\_\_ PPI \_\_\_\_\_  
           (1-20)

## Past Medical History

Please check any applicable boxes.

Item	Yes	No	Age	Item	Yes	No	Age
Measles				Skin infections, boils			
German Measles				High blood pressure			
Chickenpox				Low blood pressure			
Whooping cough				Heart disease			
Scarlet fever				Rheumatic fever			
Diphtheria				Gonorrhea			
Smallpox				Syphilis			
Poliomyelitis				Ulcers			
Meningitis				Colitis			
Pneumonia				Liver disease			
Bronchitis				Gallbladder disease			
Influenza				Kidney disease, stones			
Pneumothorax				Diabetes			
Tuberculosis				Anemia, bleeding			
Valley fever				Arthritis, rheumatism			
Histoplasmosis				Neuritis, sciatica			
Mumps				Bone disease			
Cancer				Bursitis			
Frequent colds or sore throats				Epilepsy, convulsions			
Hay fever				Malaria			
Asthma				Yellow fever			
Hives, eczema				Fungus, infections			

Surgeries not related to your pain problem: \_\_\_\_\_

\_\_\_\_\_

Family medical history, and any diseases that run in your family: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Symptom Survey

Symptoms you're now experiencing or have ever had. Please check any applicable symptoms.

Symptom	Yes	No	Please describe
Eye diseases, injury, impaired sight			
Wear glasses			
Ear disease, injury to ear, impaired hearing			
Difficulties in nose, sinuses, or mouth			
Dental problems			
Wear dentures			
Enlarged glands			
Enlarged thyroid or goiter			
Chronic or frequent cough			
Pain on taking a breath			
Chest pain at rest			
Chest pain on exertion or movement			
Coughing up blood			
Night sweats			
Shortness of breath			
Palpitation or fluttering of heart			
Extreme tiredness or weakness			
Swelling of ankles			
Varicose veins			
Pain in abdomen or stomach			
Indigestion			
Light or white stool			
Black stool or bleeding from rectum			
Mucus in stool			
Colitis or other bowel disease			

Symptom	Yes	No	Please describe
Jaundice or yellow skin			
Pain on urinating			
Frequent urination			
Bleeding with urination			
Albumin, pus, or sugar in urine			
Fainting spells			
Light-headedness or dizziness			
Black-out spells			
Convulsions			
Paralysis or muscle weakness			
Frequent or severe headaches			
Depression or anxiety			
Skin disease			
Arthritis, joint swelling, or stiffness			

Please explain any problems not listed above: \_\_\_\_\_

\_\_\_\_\_



## Wahler Physical Symptoms Inventory

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female Date: \_\_\_\_\_

Please indicate how often each of these items bothers you. Do this by circling the number to the right of each trouble that best expresses how often you're bothered by that trouble. Keep in mind that the larger the number, the **more often** the trouble bothers you. **Do not skip** any troubles.

	Almost never	About once a year	About once a month	About once a week	About twice a week	Nearly every day
1. Nausea (feeling like throwing up	0	1	2	3	4	5
2. Headaches	0	1	2	3	4	5
3. Trouble with ears or hearing	0	1	2	3	4	5
4. neck aches or pains	0	1	2	3	4	5
5. Feeling hot or cold regardless of weather	0	1	2	3	4	5
6. Arm or leg aches or pains	0	1	2	3	4	5
7. Shakiness	0	1	2	3	4	5
8. Swelling of arms, hands, legs, or feet	0	1	2	3	4	5
9. Stuttering or stammering	0	1	2	3	4	5
10. Difficulty sleeping	0	1	2	3	4	5
11. Losing weight	0	1	2	3	4	5
12. Backaches	0	1	2	3	4	5
13. Intestinal or stomach trouble	0	1	2	3	4	5
14. Difficulty with urination (passing water)	0	1	2	3	4	5
15. Heart trouble	0	1	2	3	4	5
16. Trouble with teeth	0	1	2	3	4	5
17. Numbness, or lack of feeling in any part of body.	0	1	2	3	4	5
18. Aches or pains in hands or feet	0	1	2	3	4	5
19. Fainting spells	0	1	2	3	4	5
20. Excessive perspiration	0	1	2	3	4	5
21. Abnormal blood pressure	0	1	2	3	4	5

	Almost never	About once a year	About once a month	About once a week	About twice a week	Nearly every day
22. Paralysis (unable to move parts of body)	0	1	2	3	4	5
23. Trouble with eyes or vision	0	1	2	3	4	5
24. Burning, tingling, or crawling feelings on skin	0	1	2	3	4	5
25. Skin trouble (rashes, boils, or itching)	0	1	2	3	4	5
26. Feeling tired	0	1	2	3	4	5
27. Muscular weakness	0	1	2	3	4	5
28. Dizzy spells	0	1	2	3	4	5
29. Muscular tensions	0	1	2	3	4	5
30. Any trouble with the senses of taste or smell.	0	1	2	3	4	5
31. Difficulty breathing (short of breath, asthma, etc.)	0	1	2	3	4	5
32. Twitching muscles	0	1	2	3	4	5
33. Poor health in general	0	1	2	3	4	5
34. Excessive gas	0	1	2	3	4	5
35. Difficulty swallowing	0	1	2	3	4	5
36. Seizures (convulsions or "fits")	0	1	2	3	4	5
37. Gaining weight	0	1	2	3	4	5
38. Difficulty with appetite	0	1	2	3	4	5
39. Bowel trouble (constipation or loose bowels)	0	1	2	3	4	5
40. Vomiting	0	1	2	3	4	5
41. Chest pains	0	1	2	3	4	5
42. Hay fever or other allergies	0	1	2	3	4	5

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## Please tell us how you're feeling

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Male / Female

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time	
1. I feel down-hearted, blue, and sad					
2. Morning is when I feel the best					
3. I have crying spells or feel like it					
4. I have trouble sleeping through the night					
5. I eat as much as I used to					
6. I enjoy looking at, talking to, and being with attractive women and/or men					
7. I notice that I'm losing weight					
8. I have trouble with constipation					
9. My heart beats faster than usual					
10. I get tired for no reason					
11. My mind is as clear as it used to be					
12. I find it easy to do the things I used to					
13. I'm restless and can't keep still					
14. I feel hopeful about the future					
15. I'm more irritable than usual					
16. I find it easy to make decisions					
17. I feel that I'm useful and needed					
18. My life is pretty full					
19. I feel that others would be better off if I were dead					
20. I still enjoy the things I used to do					
Please do not mark below this line. <i>Evaluation on following page.</i>					SDS Raw
					SDS Index

**Evaluation:**

**WAHLER:**

**ZUNG:**

**MCGILL:**

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