

Ohio Pain & Rehab Specialists  
6651 Frank Avenue  
North Canton, OH 44720

Phone: (330) 498-9865  
Fax: (330) 498-9869

Ohio Pain & Rehab Specialists  
87 Springside Drive  
Akron, Ohio 44333

Phone: (330) 666-6820  
Fax: (330) 666-6831

**HEALTH QUESTIONNAIRE**  
**www.ohiopainrehab.com**

**PERSONAL DATA:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Referred by? \_\_\_\_\_ Family Physician? \_\_\_\_\_

**CHIEF COMPLAINT:** (What is the reason for your visit?) \_\_\_\_\_

**HISTORY OF PRESENT PROBLEM:** When did your symptoms begin? \_\_\_\_\_

Work Injury  Auto Accident  Spontaneous Onset  Other \_\_\_\_\_

Briefly describe: \_\_\_\_\_

Ever had such symptoms in the past?  Yes  No Explain: \_\_\_\_\_

Past treatments:  Physical Therapy  Chiropractic  Nerve block  Epidural injection  Biofeedback

Surgery  Other: \_\_\_\_\_ Briefly describe response: \_\_\_\_\_

Past tests:  Labs  X-rays  MRI  EMG  Other: \_\_\_\_\_

Since the onset of your problem, have your symptoms changed?  Yes  No If so, how? \_\_\_\_\_

Are your symptoms:  Constant  Sharp  Stabbing  Burning  Throbbing  Intermittent  Dull

Shooting  Aching  Other \_\_\_\_\_

Do you experience:  Numbness  Tingling  Weakness  Other: \_\_\_\_\_

What increases your pain?:  Walking  Lifting  Lying  Twisting  Sitting  Bending  Standing

Reaching  Other: \_\_\_\_\_

What decreases your pain?  Heat  Rest  Reclining  Sitting  Walking  Ice  Activity  Standing

Other: \_\_\_\_\_

Does pain interfere with?  Work  Daily Activities  Social Life  Hobbies  Relationships

Where would you rate your pain? (mark an "x" on the line)

No pain

Worst Imaginable Pain

**Medical History**

Current Medications	Dosage	Times per Day	Condition Being Treated

**VITAMINS/SUPPLEMENTS** \_\_\_\_\_

**Patient Initials:** \_\_\_\_\_

**ALLERGIES?** (Medication, food/other)\_\_\_\_\_

**MEDICAL HISTORY:** Please check all that apply.

- Stroke  Heart Attack  High blood pressure  COPD/asthma  Blood clots
- Coronary artery disease  Peripheral vascular disease/circulation problems
- Diabetes  Kidney disease  Hepatitis  Thyroid disease  Cancer
- Coagulation disorder  Gastritis/ulcers/reflux  Psychiatric treatments  HIV/AIDS
- Other:\_\_\_\_\_

**PAST SURGERIES OR HOSPITALIZATIONS (and year):** \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_  Full time  Part time  Retired  Not working

Marital Status: **S M D W** Sep # of Children: \_\_\_\_\_

Do you have a history of drug or alcohol abuse/dependency?  Yes  No

Tobacco use:  No  Yes \_\_\_\_\_ Pack per day \_\_\_\_\_ Years

Alcohol use:  No  Yes \_\_\_\_\_ drinks per week

**FAMILY HISTORY-** (Please circle yes or no)

Diabetes	Y	N	Cancer	Y	N
High blood pressure	Y	N	Lupus	Y	N
Heart disease	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fibromyalgia	Y	N

**AT THE PRESENT TIME ARE YOU EXPERIENCING PROBLEMS WITH:**

**General:**  weight loss  weight gain  appetite changes  fever  chills  night sweats  fatigue  hard to perform usual activities  sleep disturbance

**Eyes:**  vision  discharge  pain  glaucoma  double vision  tearing  blind spots

**Ears, Nose, Throat:**  hearing  swallowing  nasal congestion  hoarseness  bleeding  dentures

**Cardiovascular:**  chest pain  fainting  leg swelling  irregular heart beats  cramping  limb discoloration  
 mitral valve prolapse  low blood pressure

**Respiratory:**  shortness of breath  cough  wheezing/asthma  blood in sputum  bronchitis

**Gastrointestinal:**  ulcers  diarrhea  constipation  heartburn  reflux  bloating  poor appetite  
 difficulty swallowing  nausea  vomiting

**Urination:**  frequent  urgent  painful  change in color  decreased stream  bloody  yeast infection  
 dribbling  incontinence  decreased sex drive  infrequent urination

**Skin:**  plaques  texture or color change  lesions  rashes  dryness  itching  hair loss  nail changes

**Endocrine:**  heat/cold intolerance  nervousness  lethargy  hypoglycemia  menopause

**Hematological:**  easy bruising  anemia  bleeding  lymph node enlargement  transfusions

**Psychiatric:**  depression  mania  anxiety  hallucinations  delusions

**Neurological:**  seizures  problems w/ balance  headache  weakness  tremor  memory  paralysis  
 incoordination  numbness  tingling  speech problems

**Musculoskeletal:**  pain  spasm  cramps  joint swelling  redness  stiffness  muscle loss

Patient Signature: \_\_\_\_\_

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