Chronic pain/Neuropathy Patient Questionnaire

Patient information:

Name: _____

Address: _____

Suburb: _____ Postcode: _____

Phone (daytime): _____

Email: _____

Date of birth: _____

Private Health Insurance provider: (if it covers alternative therapies) _____

Your condition

Name of any specific condition that you been diagnosed with: _____

Doctor that diagnosed you: _____

Have you seen a pain specialist? Yes ___ No ___ Who? _____

Have you previously had any pain procedures, blocks, or injections? YES ___ NO___

If YES please specify_____

What other health care practitioners or therapists have you seen for your condition?

_____

_____

_____

ONSET OF PAIN: What was the initial cause of the pain? _____

_____

_____

Do you have neuropathy? Yes ___ No ___ What type of neuropathy: Peripheral____
Diabetes____ Post-surgical____ Cervical/lumbar____
Post-traumatic____ Post-herpetic ____ Complex regional syndrome____ Other ____

Mark your symptoms-
Painful___ burning___ cold___ weakness___ electric shocks___ tingling___
pins and needles___ numbness___ itching___ reduced sensitivity___
increased sensitivity___ shooting pain___ pinpricks___

Other symptoms, describe in your own words-

_____

_____

_____

What number is each symptom level on a scale of 1 to 10, 10 being the worst?

_____

_____

_____

How long can you walk before having to stop due to pain? Minutes/Hours_____
How long can you sit before having to get up? Minutes/Hours_____
How long can you stand before you have to sit down? Minutes/Hours_____

What makes the symptoms worse?

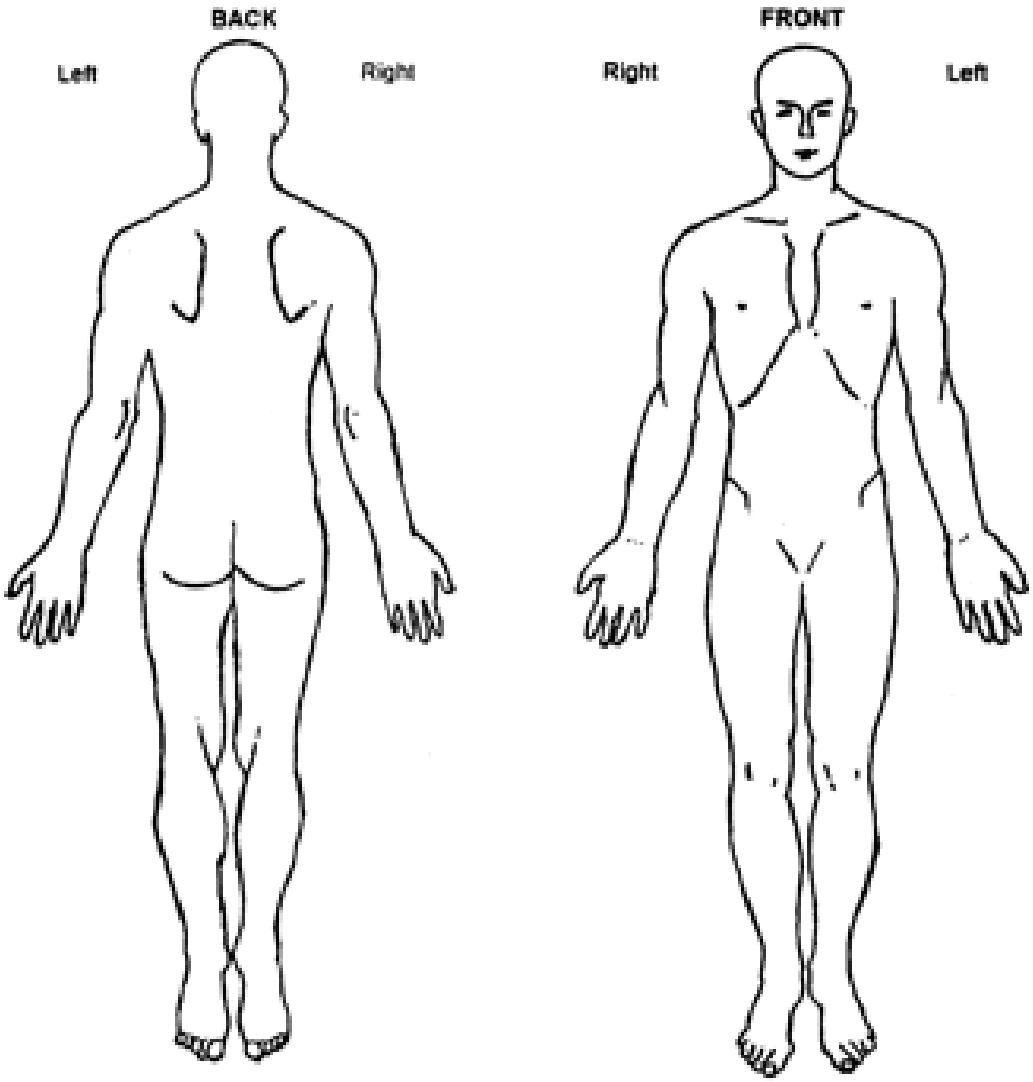
_____
_____
_____

What makes the symptoms better?

_____
_____
_____

TIMING OF PAIN: How often do you feel pain or other symptoms? (Please check one)
Constantly (100% of the time) ___
Nearly constantly (60% to 95% of the time) ___
Intermittently (30% to 60% of the time) ___
Occasionally (less than 30% of the time) ___

Please mark or shade the areas where you experience the symptoms.



Please list any medications you are currently using:
_____
_____
_____

Please list any supplements or herbs you are currently taking:
_____
_____
_____

Please list any natural therapies you have had and what percentage they have helped:
_____
_____
_____
_____

Have you had any surgeries? Yes ___ No___ Please list them and when they occurred:
_____
_____
_____

Occupation: _____

Employed full-time ___ Employed part-time ___ Unemployed ___

Exercise YES ___ NO ___ Type of exercise _____

How did you find us? _____

If internet, what did you search for? _____

Would you like to receive occasional special offers and notifications from us by email/text?
YES ___ NO ___

Consent to Treatment & Privacy statement:

I request and consent to any bodywork therapies as found appropriate.
I understand that not all risks can be anticipated or explained by my practitioner.
I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

This information will only be used for record keeping purposes and will not be shared with a third party unless legally required or your consent has been received.

Signature _____ Date _____

(Or guardian's signature if under 16 years old)