Patient Questionnaire – Anne Zuzelski, MD

New Patients or Returning Patients with New Injuries

_____ _____

Patient Name Date of Birth

What is the reason for this appointment?

_____

_____

_____

Date the condition begin? _____

Since it started, is your pain *(circle one)* ***Improving*** ***Worsening*** ***Unchanged***

Where is the pain located? _____

Does the pain travel from original position or radiate? *(circle one)* ***YES*** ***NO***

When does the pain occur *(circle one)* ***Constant*** ***Intermittent***

How do you describe your pain? Burning, stabbing, shooting, aching, etc. _____

On a scale of 1-10, 10 being the worst pain in your life, which number would choose? _____

Is it worse at any time of day? _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have numbness or tingling? Where? _____

Do you have weakness? Where? _____

Do you have any clicking, locking, catching, or swelling of the affected area? _____

_____

Have you had any imaging of the area (X-ray, MRI, CT, Ultrasound, etc)? _____

Have you tried any of the following treatments for this condition? *(circle all that apply)*

Physical therapy ***Chiropractic*** ***Massage*** ***Ice*** ***Heat*** ***Medications***

Surgery ***Injections*** ***Acupuncture*** ***Nutritional Supplements***

Other: _____

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