

JEAN-PIERRE FARCY, MD
FRANK J. SCHWAB, MD

PATIENT HISTORY AND SELF ASSESSMENT QUESTIONNAIRE

Please take a few minutes to complete this form. This information will be very helpful in establishing a diagnosis and assist in developing a treatment plan for you. This information will be placed into your records and be maintained in strict confidence.

Date:

Occupation:

Name:

Age:

Race:

Height:

Weight:

Sex:

Do you smoke?

Is your present condition related to an accident?

Your general physician:

Have you seen any specialist for this condition in the past? (Chiropractor, Acupuncturist, Physical or Occupational Therapist, etc.) Y/N Please list:

Describe in your own words your reason for seeking this evaluation, the onset and evolution of your problem.

How long have you had this pain?

Have you had surgery or ever been hospitalized for this condition?

Do you have any medical conditions? Please list:

Are you currently taking any medications? Please list type and frequency:

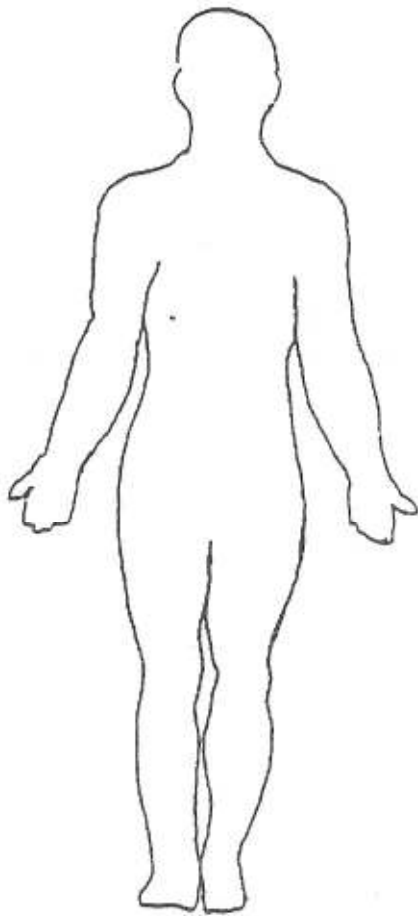
Do you have any allergies?

Please indicate your pain on the scale below by marking an X on the lines:

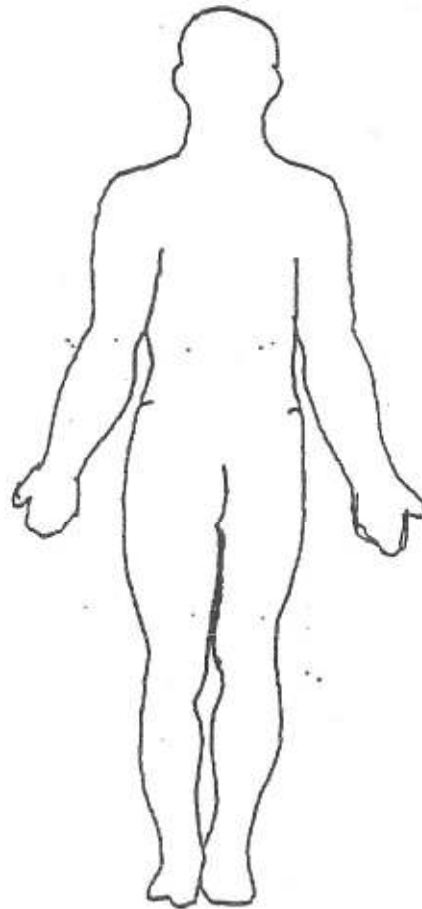
No pain

Worst pain imaginable

Please mark areas of pain,
Numbness, tingling,
or weakness on diagrams:



Front



Back

THE MOST 36-ITEM SHORT-FORM HEALTH SURVEY (SF- 36)

INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

- Excellent.....1
- Very good.....2
- Good.....3
- Fair.....4
- Poor.....5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

- Much better now than one year ago.....1
- Somewhat better now than one year ago.....2
- About the same as one year ago.....3
- Somewhat worse now than one year ago.....4
- Much worse than one year ago5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

ACTIVITIES	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited At All
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other activities	1	2
d. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a. Cut down the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(circle one)

- Not at all.....1
 Slightly.....2
 Moderately.....3
 Quite a bit.....4
 Extremely.....5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

- None.....1
 Very mild.....2
 Mild.....3
 Moderate.....4
 Severe.....5
 Very severe.....6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

- Not at all.....1
 A little bit.....2
 Moderately.....3
 Quite a bit.....4
 Extremely.....5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please find the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks--

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

Copyright 1932 MOS Trust, Inc.
 All rights reserved.

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

- All of the time.....1
- Most of the time.....2
- Some of the time.....3
- A little of the time.....4
- None of the time.....5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5