CSN- RETURN PATIENT INFORMATION QUESTIONAIRE

Date of Birth

Name

Shade the location(s) you have pain or numbness:

Has your pain or numbness changed since last visit?					(1-) 1-1	}			
Circ	le the words bel	low that des	scribe your	pain:		/		Je1/ 1	12 mg/201
		Aching	Sharp		Constar		11-1	\\]//)/ M
		Throbbing	Stabbing		Occasio	al प्रिकेश	f(X)	The Ten	A4
	Prickling	Dull	Shooting	ı F	requer		\		
		Cramping	Stinging		Rare		1:35:1		
Pair	n with medicatio	ons/therapy:	:	1					
							Medical History-		
0	1 2 3	4 5	6 7	8	9				
No					W		Status:		
Pain Pain	n without medic	ations/thera	ару:		P		hanges with your	health since last vi	sit
 0 No	1 2 3	 4 5	6 7	8	9 W		nanges in medica	itions since last visit	t
Pain					P		the number to des	cribe your average da	nily function
	iew of Systems							 5 6 7	
	e all past/present stitutional:	symptoms:				0 1 None	1 2 3 4	5 6 7	8 9 10 Full
		Chills		Swea	ating	None		5 6 7	
Cons	Appetite Change Fever				eating ght Cha	None Allergy	/Immunology:		Full
	Appetite Change Fever	Chills				None Allergy Imr	//Immunology:	5 6 7 Food allergies	
Cons	Appetite Change Fever T Neck pain	Chills		Weig	ght Cha Pain	Allergy Imr Neuro:	r/Immunology:	Food allergies	Full Recent infection
HEN	Appetite Change Fever T Neck pain Sore Throat	Chills Fatigue	tiffness	Weig	ght Cha	Allergy e Imr Neuro:	r/Immunology: munocompromised eadache	Food allergies Dizziness	Recent infection Numbness
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	1.	How	lona	have	vou	had	head	laches:
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- 2. How many days per month are you headache FREE:
- 3. How many headache days do you have per month:
- 4. How many hours per day do your headaches last: _
- 5. Over the past 3 months has the frequency changed:

More often Less Often No cha	ange
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6. What symptoms do you normally have with your headaches:

Moderate Pain	Severe Pain	Sensitivity to light
Sensitivity to sound	Nausea	Pain on one side
Vomiting	Vision changes	

7. How many days per month do you have one of the above symptoms:

	•	•	•			
0-4			5-9	10-14	15+	Ì

- 8. On a scale of 1-10, 1 being mild, rate your typical headache:
- 9. Do you experience any symptoms prior to developing a headache, describe:
- 10. Do you have any triggers: _
- 11. Days last month you missed work/school due to headache:

0	1-2	3-4	5+
•	- =		_

2. Days last month you cancelled plans due to headache:

0	1-2	3-4	5+

13. Times last year you went to the emergency room due to headache:

0	1-2	3-4	5+

14. Circle below if you have tried this medication or treatment and it was not effective in the past

Amitriptyline	Elavil	Nortriptyline	Pamelor
Effexor	Venlafaxine	Depakote	Divalproex
Topamax	Topiramate	Valpric acid	Gabapentin
Metoprolol	Propranolol	Verapamil	Botox
Occipital block	Tylenol	NSAIDS	Ibuprofen
Naproxen	Sumatriptan	Imitrex	Zolmitriptan
Zomig	Rizatriptan	Maxalt	Oxycodone
Percocet	Hydrocodone	Vicodin	Ubrevly