CSN- RETURN
PATIENT INFORMATION
QUESTIONAIRE

_____

Name Date of Birth

Has your pain or numbness changed since last visit?

_____

Circle the words below that describe your pain:

Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare

Pain **with** medications/therapy:

|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Pain **without** medications/therapy:

|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Review of Systems

Circle all past/present symptoms:

Constitutional:

Appetite Change	Chills	Sweating
Fever	Fatigue	Weight Change

HENT

Neck pain	Neck Stiffness	Ear Pain
Sore Throat	Congestion	Sinus Pressure

Eyes:

Eye Pain	Blurred Vision	Double Vision

Respiratory:

Apnea	Shortness of breath	Cough

Cardiovascular:

Chest pain	Swelling	Palpitations

Gastrointestinal:

Nausea/Vomiting	Constipation	Diarrhea

Endocrine:

Thyroid problems	Elevated glucose	Sexual difficulties

Genitourinary:

Incontinence	Hesitancy	Urgency

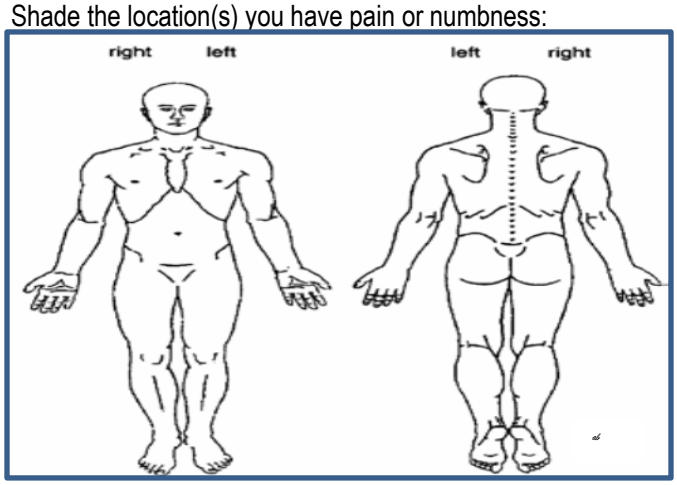
Musculoskeletal:

Arthralgia	Back Pain	Gait Disturbance

Skin:

Color Changes	Rash	wounds

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



Past Medical History- Update

List new allergies:_____

Work Status:_____

Any changes with your health since last visit_____

_____

List changes in medications since last visit_____

_____

Circle the number to describe your average daily function

|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

None — Full

Allergy/Immunology:

Immunocompromised	Food allergies	Recent infection

Neuro:

Headache	Dizziness	Numbness
Weakness	Confusion	Seizures

Hematologic:

Anticoagulation	HIV	Bleeding disorder

Psychiatric:

Depression/anxiety	Substance abuse	Suicidal thoughts

Provider Notes

HR:____ BP:____ RR:____ Sat___ Wt____ T____

Headache Assessment Update:

1. How long have you had headaches: _____
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 change

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+

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