

# PATIENT CONDITION QUESTIONNAIRE (PCQ)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

1) Briefly describe the problem (s):

\_\_\_\_\_

\_\_\_\_\_

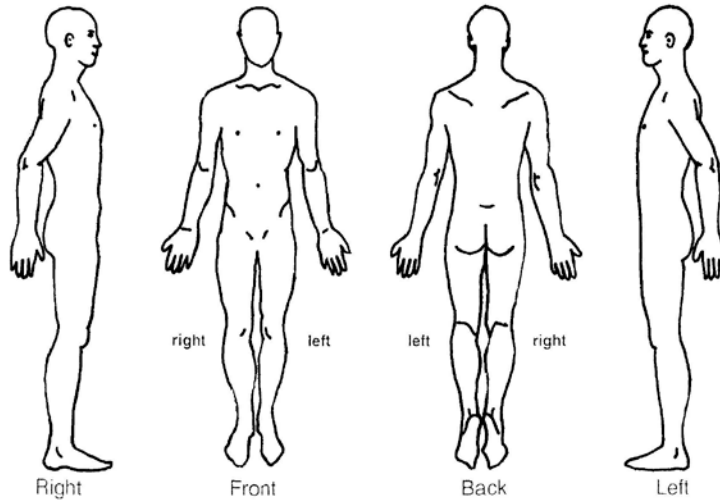
\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

2) Please indicate the location of your pain/symptoms on the diagram below. Use the symbols to best describe the type(s) of pain/symptoms you have:

D= Dull Ache    N= Numbness    T= Tingling (Pins & Needles)  
 B= Burning    S= Sharp    Z= Stiffness / Tight



3) When did this condition / injury become a problem?

\_\_\_\_\_

4) Have you had a similar episode(s) before?

No     Yes, Date(s): \_\_\_\_\_

5) Have you seen any other healthcare providers for this condition?  No     Yes

If yes, who did you see? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

\_\_\_\_\_

6) Have you had X-Rays, MRI, Etc. for this condition?

No     Yes, Date: \_\_\_\_\_

7) Mark your average pain level on the line below.

Least Pain \_\_\_\_\_ Worst Pain

8) Mark your pain level at its worst on the line below.

Least Pain \_\_\_\_\_ Worst Pain

9) Please list your top 3 problem areas below and circle your frequency of pain/symptoms to the right of each one.

I) \_\_\_\_\_ Seldom - Intermittently - Occasionally - Frequently - Constantly - Other: \_\_\_\_\_

II) \_\_\_\_\_ Seldom - Intermittently - Occasionally - Frequently - Constantly - Other: \_\_\_\_\_

III) \_\_\_\_\_ Seldom - Intermittently - Occasionally - Frequently - Constantly - Other: \_\_\_\_\_

10) Pain Better:  a.m.     mid-day     p.m.     at rest     does not change     other: \_\_\_\_\_

11) Pain Worse:  a.m.     mid-day     p.m.     at rest     does not change     other: \_\_\_\_\_