

FIBROMYALGIA

Survey

Name _____ Age _____

Phone (Home) _____ (Cell) _____

Address _____

City _____ State/Prov. _____ Zip/Postal _____

E-mail address: _____

Occupation _____ # Hours per week currently working _____

Spouse Occupation _____ # Hours per week currently working _____

Check off any of the following symptoms you have experienced in the past 6 months:

- | | | |
|------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vaginal Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty with Breathing | <input type="checkbox"/> Communication Problems |
| <input type="checkbox"/> Emotional Instability | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> In Severe Low Back and Hip Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mild to Severe Body Pain | <input type="checkbox"/> Forgetful and Foggy Mindedness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Trigeminal Neuralgia | <input type="checkbox"/> Interstitial Cystitis |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Calcium Deposits Under the Skin | <input type="checkbox"/> Awakes Exhausted |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Rashes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Rectal Spasms | <input type="checkbox"/> Suicidal Tendencies |

Which of the above bothers you the most? _____

How long have you been bothered by the condition? _____

Describe how it feels or affects you when it is at its worst. _____

Do any of the following aggravate your problem:

- Excessive Physical Activity Physical Inactivity Cold or Humid Weather Physical or Mental Fatigue

Does this affect your work:

- Making Decisions Poor Attitude Decreased Productivity
 Exhausted at End of Day Unable to Work Long Hours

Does this affect your life:

- Lose Patience with Spouse or Children Hinders Ability to Exercise or Participate in Sports
 Restricted Household Duties Interferes with Ability to Participate in Hobbies or Other Desired Activities

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There are several alternatives available to you. Please check the item most appropriate for you.

I would like to come to the office to discuss my health problems at no cost. This will allow me to find out if I can be helped without any financial barriers.

I would like the office to call me to answer some questions before making an appointment.

The best time for me to come to the office this week would be _____ (day) and at _____ am/pm (time)

If the day and time you chose is available or not available we will call you to either confirm or reschedule it.