MANHATTAN
PAIN MEDICINE

eHSD/EDS Intake Questionnaire

Which of the following are "Yes":

- ☐ Can you now (or could you ever) bend your thumb to touch your forearm?
- ☐ As a child, did you amuse your friends by contorting your body into strange shapes or could you do the splits?
- ☐ As a child or teenager, did your shoulder or kneecap dislocate on more than one occasion?
- ☐ Do you consider yourself "double jointed"?

Which of the following have you had?

- ☐ Skin hyperextensibility
- ☐ Unexplained striae
- ☐ Atrophic scarring
- ☐ Recurrent or multiple hernias
- ☐ Dental crowding and high or narrow palate
- ☐ Mitral valve prolapse (MVP)
- ☐ CCI
- ☐ Chiari
- ☐ Brain Fog
- ☐ Blurry Vision
- ☐ Upright Position intolerance
- ☐ Headache
- ☐ Dental Issues
- ☐ TMJ/TMD (Jaw joint)
- ☐ Neck Pain
- ☐ TOS (Thoracic Outlet Syndrome)
- ☐ Peripheral nerve entrapments
- ☐ Shoulder subluxation
- ☐ Ganglion cysts
- ☐ Multiple site of tendonitis
- ☐ Slipping Ribs
- ☐ Costochondritis
- ☐ Abdominal Pain
- ☐ Hernias: _____
- ☐ SMAS (Sup. Mesenteric Art.)
- ☐ MALS (Median Arcuate Ligt.)
- ☐ SIBO (Small Intest. Bact. Overgrowth)
- ☐ Gastroparesis
- ☐ Acid Reflux
- ☐ Chronic Nausea
- ☐ Chronic Constipation
- ☐ Back Pain
- ☐ Bertolotti Syndrome/ LSTV
- ☐ Tethered Cord
- ☐ Tarlov Cysts
- ☐ Sacroiliac Joint pain
- ☐ Hip labral tears
- ☐ Pelvic Pain
- ☐ Pelvic prolapse
- ☐ Pelvic floor dysfunction
- ☐ Pelvic Congestion (May Thurner, Nutcracker)
- ☐ MCAS (Mast Cell Activation Synd.)
- ☐ SFN (Small Fiber Neuropathy)
- ☐ Autoimmune
- ☐ POTS (Postural Tachycardia)
- ☐ Exercise intolerance
- ☐ Attention Deficit
- ☐ Neurodivergence
- ☐ _____
- ☐ _____

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Who are your **current treating providers?** (May attach list)

Name	Role	Contact

Current* medications** with ***Dosages and ***Response/side effects.*** (May attach list)

Medication	Dose	Effect

Past* medications** with ***Dosages and ***Response/side effects.*** (May attach list)

Medication	Dose	Effect

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Please **Name** and **Describe** the TOP FOUR pains to address

1. _____
2. _____
3. _____
4. _____

Trauma - Has there been any physical trauma to any area? (Describe):

_____

Were any of the above pains associated with the trauma? (circle) 1 2 3 4

Hormones - Is there any cyclical variation in any of the pain(s) (i.e. w/ menstruation)? 1 2 3 4

_____

Nerve Involvement - Do you feel altered sensation, burning, itching, pins/needles? 1 2 3 4

_____

Sensitization - Hypersensitivity: intolerance of light touch, heat/cold, pressure? 1 2 3 4

_____

Autoimmune - Do you have any autoimmune conditions? Anyone in your family?

_____

Mechanics - Which activities trigger which pain?

Sitting	1	2	3	4
Standing	1	2	3	4
Walking	1	2	3	4
Stairs	1	2	3	4
Travel	1	2	3	4

Sleeping	1	2	3	4
Sidelying	1	2	3	4
Toileting	1	2	3	4

Other:
_____

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Procedures - How has each procedure affected each pain?

Procedure	1	2	3	4

Template for Tracking Future Responses

List Each Symptom	Medication 1	Diagnostic Block 1	PT	Medication 2	Diagnostic Block 2...
1					
2					
3					
4					