



# FIBROMYALGIA

## Patient Information Form

As you read through and fill out these questions please understand that this is an application to Dr. Moleski's Fibromyalgia Relief Program. This is NOT a guarantee of acceptance. Dr. Moleski will be assessing your case. This Program is only for patients with severe symptoms. Dr. Moleski **ONLY** works with patients who are tired of (or who don't want to take) medications or those who want an alternative to dangerous injections. If you are not serious about finding a solution to your problem, please be respectful of his time and he will do the same for you.

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_ Sex: M F  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_

I (signature) \_\_\_\_\_ consent to allow Dr. Moleski to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for the Fibromyalgia Relief Program and also to determine if he is willing to accept my case. It is also my understanding that the consultation is at no charge.

In Reference To The Severity, How Would You Rate Your Problem On A Scale Of 0-10 (10 being the worst)? \_\_\_\_\_

What Is Your Reason For Requesting A Consultation With The Doctor?  
\_\_\_\_\_  
\_\_\_\_\_

How Do You View Your Problem (circle one)... MINIMAL (Annoying, but causing NO limitations)  
SLIGHT (Tolerable, but causing a little limitation)  
MODERATE (Sometimes tolerable, but definitely causing limitations)  
SEVERE (Causing significant limitations)  
EXTREME (Causing near constant (>80% of the time) limitations)

1. What are you hoping happens today as a result of the doctor spending time with you?  
\_\_\_\_\_  
\_\_\_\_\_

2. How long have you been like this?  
\_\_\_\_\_

3. What changes/modifications have you had to make and how has your lifestyle changed since your Fibromyalgia began?  
\_\_\_\_\_  
\_\_\_\_\_

4. Please check the following kinds of treatment you received?

Surgeries: \_\_\_\_\_  
Injections: \_\_\_\_\_  
Drugs/Pharmaceuticals: \_\_\_\_\_  
Physical Therapy: \_\_\_\_\_  
Chiropractic: \_\_\_\_\_  
Diet/Nutrition: \_\_\_\_\_  
Exercise: \_\_\_\_\_

5. Did any of these treatments seem to work in helping your condition? If so, which one(s)? For how long?

---

---

6. What actions can you take that temporarily decrease the pain?

---

---

7. What activities/movements are guaranteed to increase your pain and worsen your condition?

---

---

8. What does the pain feel like (sharp, dull, achy, shooting, stabbing, numb, tingling, etc...) and where?

---

---

9. What does it feel like when you wake up compared to the rest of the day? Is it worse in the morning or the evening?

---

---

**What percentage of time are you aware of your condition? (circle one)**

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constantly (90-100% of the time)

**Due To Your Main Problem.....**

Have You Lost Any Time From Work? Yes No

How Much Time and What Have You Been Unable To Perform? \_\_\_\_\_

Have You Lost Any Time From Your Obligations At Home? Yes No

How Much Time and What Tasks Have Been Limited? \_\_\_\_\_

Have You Lost Any Time From Your Family? Yes No

How Much Time and What Tasks Have Been Limited? \_\_\_\_\_

Have You Lost Any Time From Enjoying Your Leisure Activities? (Hobbies, Travel, Sports, etc...)? Yes No

How Much Time and What Tasks Have Been Limited? \_\_\_\_\_

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?

---

**On a Scale of 0-10 (10 being unbearable, 0 being no pain or discomfort) Please rate the following...**

The HIGHEST your pain gets WITHOUT medication \_\_\_\_\_

The LOWEST your pain gets WITHOUT medication \_\_\_\_\_

The HIGHEST your pain gets WITH medication \_\_\_\_\_

The LOWEST your pain gets WITH medication \_\_\_\_\_