PAIN QUESTIONNAIRE

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THE FOLLOWING MULTI-PAGE QUESTIONNAIRE IS A **VERY** IMPORTANT TOOL THAT IS USED TO ASSESS YOUR PAIN CONDITION AS WELL AS THE **APPROPRIATE** TREATMENTS FOR YOUR PROBLEM.

PLEASE READ AND FILL OUT EVERY SINGLE ITEM IN THIS FORM, INCLUDING THE **DEMOGRAPHIC INFORMATION** ON THE FIRST TWO PAGES. PLEASE ALSO INCLUDE YOUR **SIGNATURE** WHERE REQUESTED. FAILURE TO COMPLETE OR SIGN THIS FORM COULD RESULT IN A DELAY IN YOUR APPOINTMENT.

PLEASE BRING THE COMPLETED FORM ALONG WITH ANY PERTINENT FILMS, REPORTS, DOCTOR NOTES, **COMPLETE MEDICATION LIST,** AND **PRESCRIPTION BOTTLES** FOR YOUR **INITIAL** CONSULTATION.

THANK YOU VERY MUCH IN ADVANCE FOR YOUR COOPERATION!!!

Name: ______________________________Date: ________________ Height: _______________

Weight: ___________________ Social Security Number: ________________________________

Date of Birth: ___________________________ Age: ____________________________________

Street Address: ____

City: _____________________State: ______________________ Zip: ______________________

Home Phone: ______________Work Phone: _______________ Cell Phone: ________________

Email Address: ____

Employer's Name & Address: ____

Spouse's Name: ____

EMERGENCY CONTACT (PERSON LIVING WITH YOU):

Name: ____

Relation to You: _________________________Phone Number: ___________________________

INSURANCE INFORMATION

Primary Insurance Name: ______________________________

Claims Address: ______________________________

Subscriber's Name: ______________________________

Subscriber's Date of Birth: ______________________________

ID #: ______________________________

Group #: ______________________________

Subscriber Relation to Patient: Self ____ Spouse ____ Child ____ Other ____

Secondary Insurance Name: ______________________________

Claims Address: ______________________________

Subscriber's Name: ______________________________

Subscriber's Date of Birth: ______________________________

ID #: ______________________________

Group #: ______________________________

WHO is your Referring Physician?
Name: ______________________________

Address: ______________________________
____

Phone: ____________________ Fax: ____________________

WHO is your Primary Care Physician?
Name: ______________________________

Address: ______________________________
____

Phone: ____________________ Fax: ____________________

Orthopedic surgeon: ____

Neurologist: ____

Neurosurgeon: ____

Rheumatologist: ____

Chiropractor: ____

HAVE you been to another Pain Physician? ___Yes __No If yes, who? ____________________

PAIN HISTORY

PLEASE DESCRIBE YOUR PAIN PROBLEM

1. WHERE is your pain?

____
____
____

2. WHERE does the pain spread or radiate?

____
____
____

3. WHEN did your pain begin?

____
____
____

4. HOW did your pain begin? (Please check one and describe below)

___Pain just started by Itself ____
(Date Pain Started)

___Accident at Work ____
(Date of Accident)

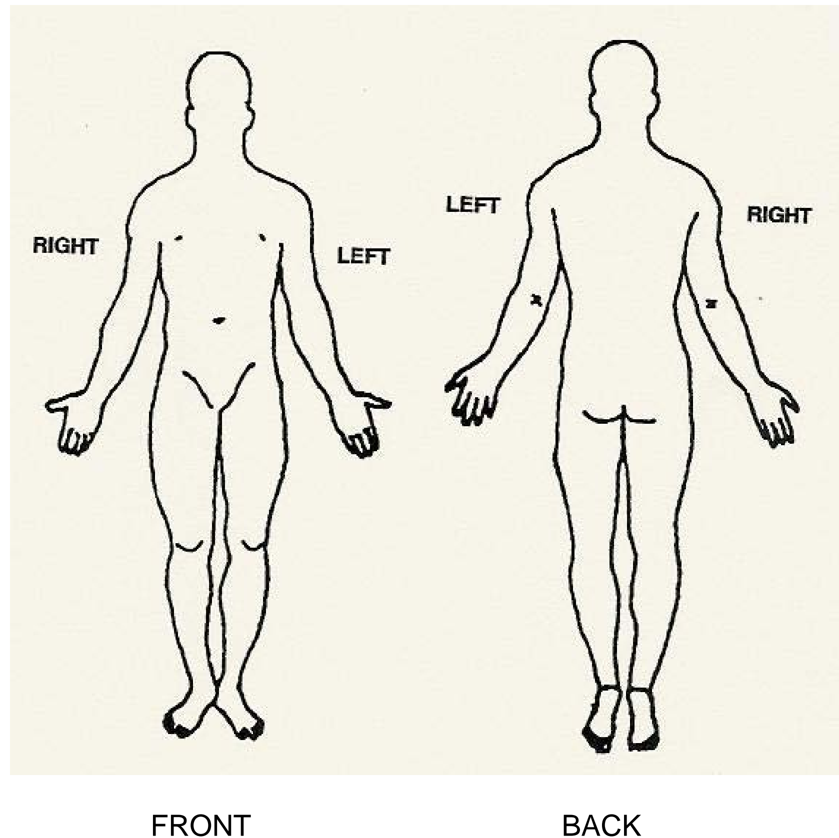
___Accident at Home Motor Vehicle ____
(Date of Accident)

___Accident following Surgery ____
(Date of Accident)

___Following Illness ____
(Date of Illness)

___Other Reason ____
(Description & Date of Incident)

Please use the diagram below to demonstrate where your pain is located by shading the areas that are painful



FRONT BACK

5. WHAT DOES YOUR PAIN FEEL LIKE? Please circle any of the words below which describes the character of your pain:

1	2	3	4
Sharp	Dull	Annoying	Penetrating
Burning	Aching	Miserable	Piercing
Electricity	Sore	Intense	Tight
Shooting	Hurting	Unbearable	Numb
Stabbing	Heavy	Troublesome	Squeezing
Lancinating	Tender	None	Cool
Tingling	Tiring		Cold
Throbbing	Sickening		Nauseating
Pounding	Terrifying		Agonizing
Cramping	Punishing		Dreadful
Crushing	Blinding		Torturing
Pulling			

6. **HOW DOES YOUR PAIN CHANGE WITH TIME? Please circle any of the words below that describe the <u>pattern</u> of you pain:**

1	2	3
Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

7. **ACTIVITY/BODY POSITION:**
Which activities or body positions (e.g. walking, bending, etc.) bring on or WORSEN your pain?

____

____

Which activities or body positions (e.g. sitting, lying down, etc.) seem to IMPROVE your pain?

____

____

8. **Which symptoms are associated with your pain (check <u>all</u> that apply):**

__ Weakness of arm(s) - Left / Right / Both
__ Weakness of leg(s) - Left / Right / Both
__ Numbness of arm(s)- Left / Right / Both
__ Numbness of leg(s) - Left / Right / Both
__ Loss of bladder or bowel control
__ Tenderness of affected area
__ Cool, pale skin
__ Discolored or mottled skin
__ Impotence
__ Decreased sex drive
__ Depression
__ Other: ____

__ Headaches
__ Pain with only light touch
__ Weight gain (How many lbs. past 6 mos? ______)
__ Weight loss (How many lbs. past 6 mos? ______)
__ Difficulty sleeping
__ Pain awakens you at night
__ Fever

9. **Please help us to rate your pain on a numerical scale:**
(0= No Pain At All 10= The Worst Pain Imaginable)

Today	0 1 2 3 4 5 6 7 8 9 10
On good days:	0 1 2 3 4 5 6 7 8 9 10
On bad days:	0 1 2 3 4 5 6 7 8 9 10
Average past week	0 1 2 3 4 5 6 7 8 9 10
Average past month	0 1 2 3 4 5 6 7 8 9 10

10. **How does pain affect your lifestyle? (What can you no longer do because of your pain condition?)**

____

____

____

11. **Which TREATMENTS have been used for your pain? (Check all that apply)**

	Helpful?	WHEN did you receive this treatment?
__ Pain Killers	Yes__ No__	______________________________
__ Anti-Inflammatory Meds	Yes__ No__	______________________________
__ Muscle Relaxants	Yes__ No__	______________________________
__ Bedrest	Yes__ No__	______________________________
__ Physical Therapy	Yes__ No__	______________________________
__ Exercise	Yes__ No__	______________________________
__ TENS (electrical stim)	Yes__ No__	______________________________

PRIOR TREATMENTS (continued):

	Helpful?	WHEN did you receive this treatment?
__ Chiropractic Therapy	Yes__ No__	______________________________
__ Traction	Yes__ No__	______________________________
__ Cortisone Injections	Yes__ No__	______________________________
__ Epidural Injections	Yes__ No__	______________________________
__ Other Nerve Blocks	Yes__ No__	______________________________
__ Surgery	Yes__ No__	______________________________
__ Psychotherapy	Yes__ No__	______________________________
__ Biofeedback	Yes__ No__	______________________________

__ Other ____

Please list any medication(s) that you have taken *in the past* for your condition which has/have __NOT__ helped to reduce or relieve your pain: ____

____

____

____

____

____

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____

PAST MEDICAL & SURGICAL HISTORY:

12. **Have you ever been diagnosed with or treated for any of the following health problems? (Please check and circle all items that apply)**

__ Angina / Chest Pain
__ Angioplasty or Stent for blocked artery
__ Anxiety, Depression, or Panic Disorder
__ Arrhythmia/Atrial Fibrillation /Cardiac Arrest
__ Arthritis (Type?: Osteo / Rheumatoid)
__ Asthma / Wheezing
__ Bipolar Disorder
__ Bleeding Disorder (Hemophilia, ITP, etc.)
__ Cancer (Type ______________________)
__ Chronic Cough
__ Congestive Heart Failure (year? ______)
__ Deep Venous Thrombosis (Blood Clot Leg)
__ Diabetes (__ Type I __ Type II)
__ Drug or Alcohol Abuse / Addiction
__ Emphysema, Chronic Bronchitis, or COPD
__ Fibromyalgia
__ Headache (Migraine, Cluster, or Tension ?)
__ Heart Attack (year? ____________)
__ Hepatitis (Circle Type: A / B / C)
__ High Blood Pressure
__ HIV or AIDS
__ Implantable Defibrillator
__ Kidney Failure / Dialysis
__ Liver Disease / Cirrhosis
__ Neuropathy (Type? _________________)
__ Obesity
__ Pacemaker
__ Paralysis (Describe__________________)
__ Previous Suicide Attempt
__ Pulmonary Embolism (blood clot to the lung)
__ Seizure or Epilepsy
__ Sickle Cell Disease
__ Stomach or Duodenal Ulcer (Year _____)
__ Stroke or TIA
__ Thyroid Disease (Under or Overactive?)

13. **Please list any SURGERY(s) and date of surgery you have had in the past:**

Surgery	Date of Surgery

ALLERGIES:

14. **Please list your ALLERGIES TO MEDICATIONS or OTHER DRUGS:**

Name of Medication	Type or Reaction Experienced

15. **Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)?** __Yes __ No

If **yes**, what type of reaction did you have?

____

16. **Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen)?** __Yes __No

CURRENT MEDICATIONS:
Bring all current medications including **PRESCRIPTION BOTTLES** to initial office visit

17. **Please list the medications which you currently take strictly <u>FOR PAIN</u>:**

Name of Pain Medication	Dosage and Number of pills per day
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

18. **Please list the medications which you currently take FOR OTHER MEDICAL CONDITIONS:**

Name of Medication	Prescribing Physician
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

19. **Do you take Aspirin?** __Yes __No

20. **Do you take Coumadin, Plavix, Pletal, Aggrenox, or Ticlid?** __Yes __No

21. **Do you take any herbal medications?** __Yes __No

If **yes**, please list them all: ____

SOCIAL HISTORY

23. **What is your current marital status? (Please check one)**

__ Single __ Married __ Divorced __ Widowed __ Separated

24. **Do you currently smoke cigarettes?** __Yes __ No

If **yes**, how many packs per day? ____________ How many years? ______________

25. **Do you drink alcohol?** __Yes __ No

If **yes**, how much per day? __________________ How many years? ______________

26. **Have you ever been diagnosed with or treated for drug or alcohol abuse?** __Yes__No

If **yes**, when? ____

27. **Are you currently or have you ever used illicit drugs?** __Yes__ No

If **yes**, what drug and when was the last time used? ________________________________

WORK HISTORY

28. **What is your employment status? (Please check one)**
___ Able to work but currently unemployed
___ Homemaker
___ Not working; on Disability since (date) ______________________________
___ Not working; on Worker's Comp. leave from my job since (date) ______________
___ Retired
___ Student
___ Working Full Time (___ Light Duty)
___ Working Part Time

29. **What is (was) your occupation or job title? (Please describe)**
____
____
____

30. **Which of the following are regular requirements of your job? (Check all that apply)**
___ Computer Work
___ Frequent Stooping, Bending, Twisting
___ Heavy Lifting (over 30 pounds)
___ Light Lifting (15-30 pounds)
___ Standing for Long Periods of Time (over one hour at a time)
___ Sitting for Long Periods of Time (over one hour at a time)
___ Other Physical Requirements; Describe: ______________________________
____

31. **Which diagnostic studies have been performed to evaluate your pain problem? (Write the dates of the diagnostic studies for all that applies)**
X-Ray ______________ MRI ____________________ CT Scan ________________
EMG/NCS ________________________ Blood tests ____________________________

If you have had **ANY** imaging done, please **BRING** copies of the reports or films (including EMG/NCS, MRI, CT-scan, or X-rays) to office visit.

I certify that I have answered all of the above questions truthfully and to the best of my ability.

____ ________________________
Patient Signature Date