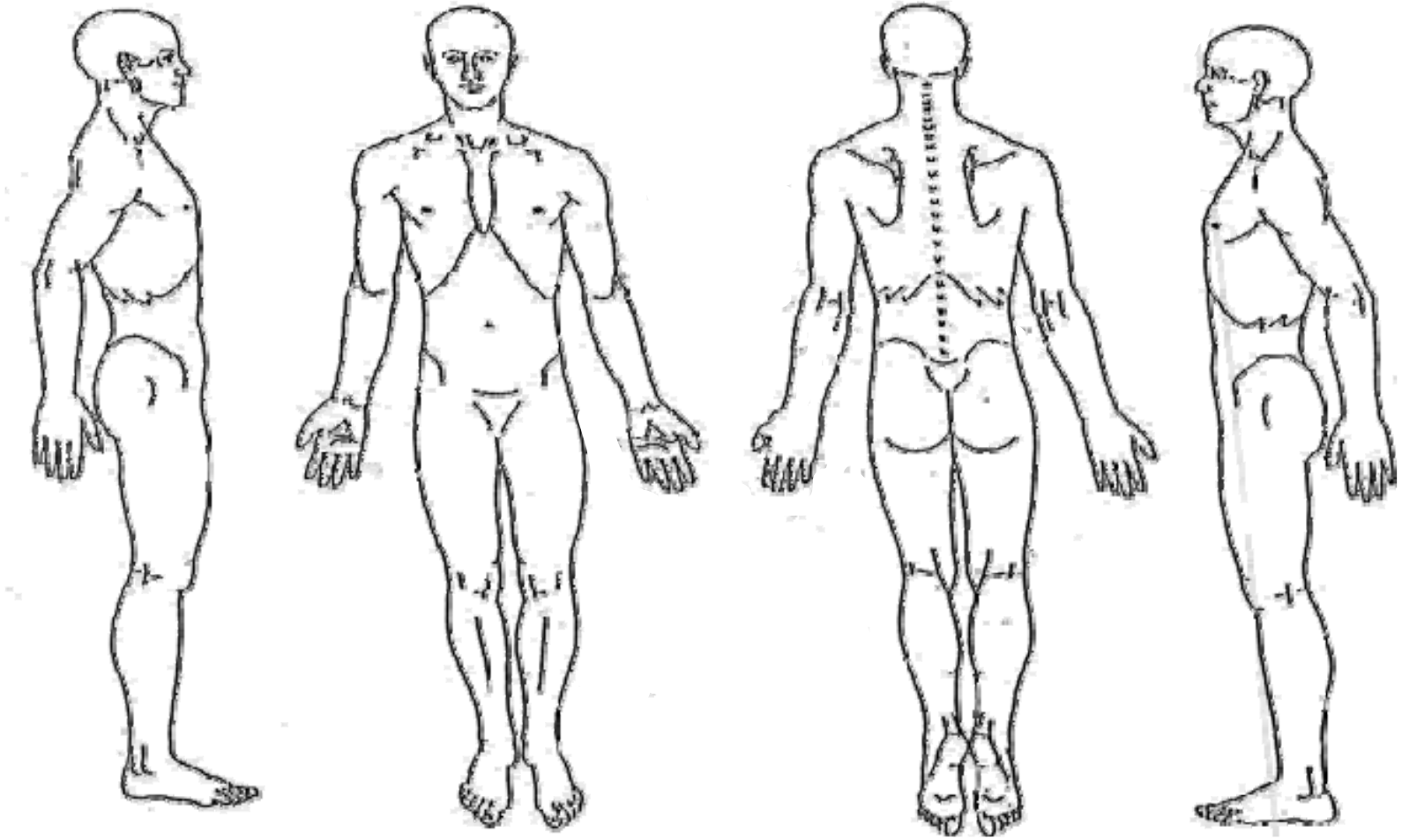
PAIN QUESTIONNAIRE

Patient Name: _____

Appointment Date: _____

Please mark and/or notate the areas of your body which are affected by pain.

RIGHT RIGHT LEFT LEFT RIGHT LEFT



RIGHT RIGHT LEFT LEFT RIGHT LEFT

For Office Use Only:

Insurance Type: _____

Body Parts: _____

Physician: _____

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

PAIN QUESTIONNAIRE

Name: _____Age: _____ DOB: _____

1. In addition to page 1, please specify your pain complaint and the location*(s)* on your body.

   _____

   _____

2. When were you *first* injured? _____
3. When was the *first* time you experienced pain? _____
4. When was the *first* time you saw a doctor for your injury? _____
5. On a scale of 1-10 *(10 being the worst)*, how would you rate your pain? _____
6. Has your pain changed since the time of your injury? (i.e. better, worse, stable)

   _____

   _____

7. If your pain radiates, where does it radiate to? (i.e. up left arm, down right leg, etc…)

   _____

   _____

8. Is there a daily cycle to your pain? (i.e. pain worse at night-time)

   _____

9. How frequently does your pain occur? Do you have pain-free periods? Does your pain change in intensity during the course of the day?

   _____

   _____

   _____

   _____

10. Briefly describe how the injury occurred:

    _____

    _____

    _____

    _____

    _____

11. Excluding surgery, please describe all medical events *after* the injury in sequential order.

Doctor or Medical Center	Diagnosis	Treatments	Did it help?

12. What diagnostic studies (MRI, CT, EMG, Labs) have been performed to evaluate your pain?

Test	Date	Results

NON-WC PAIN QUESTIONNAIRE

13. Have you *previously* had problems with the body part*(s)* that is/are currently injured? Please explain:_____

_____

_____

14. Please **CIRCLE** the words that describe your pain.

ACHING, ACUTE, BURNING, CHRONIC, CONSTANT, CRAMPING, DULL, GNAWING, INTERMITTENT, MILD, MODERATE, NUMBNESS, SEVERE, SHARP, STABBING, TEARING, THROBBING, TINGLING

15. What makes your pain *better*?

_____

_____

16. What makes your pain *worse*?

_____

_____

17. Do you experience any numbness of tingling? Please explain.

_____

18. Have you developed any sexual dysfunction since the injury? **Y/N** If yes, please explain.

_____

19. Have you unintentionally gained or lost weight since the injury? **Y/N** If yes, how much?

_____

TREATMENT HISTORY

1. Have you ever had any of the following treatments? What was the result?

	Major Relief	Some Relief	No Relief	Worse
_____ Acupuncture	_____	_____	_____	_____
_____ Biofeedback	_____	_____	_____	_____
_____ Chiropractor	_____	_____	_____	_____
_____ ER Visit **date:**	_____	_____	_____	_____
_____ Hypnosis	_____	_____	_____	_____
_____ Massage	_____	_____	_____	_____
_____ Physical Therapy	_____	_____	_____	_____
_____ Psychotherapy	_____	_____	_____	_____
_____ TENS Trial	_____	_____	_____	_____
_____ Surgery	_____	_____	_____	_____

_____ Other (Specify) _____ _____ _____ _____
_____

2. Who is your primary treating physician or the doctor who assesses your disability status?

Name: _____

Phone: _____

Address: _____

_____

Would you like your primary treating physician to receive updates on your treatment here? **Y/N**

REVIEW OF SYSTEMS

Height: _____ Weight: _____

Check if you are **CURRENTLY** experiencing any of the following:

_____ Weight loss
_____ Night sweats
_____ Headaches
_____ Double vision
_____ Floaters (vision)
_____ Blurred vision
_____ Neck pain
_____ Lumps in the neck
_____ Neck stiffness
_____ Chronic cough
_____ Wheezing
_____ Difficulty breathing
_____ Chest pain
_____ Vomiting
_____ Diarrhea
_____ Black stool
_____ Nausea
_____ Constipation
_____ Coughing / vomiting blood
_____ Excessive gas
_____ Frequent heartburn
_____ Urgency
_____ Irregular bowel movements
_____ Burning or painful urination
_____ Inability to urinate
_____ Back Pain
_____ Joint stiffness
_____ Muscle pain
_____ Yellow skin
_____ Weakness
_____ Seizures
_____ Balance problems
_____ Tremor or shaking
_____ Easy bruising or bleeding
_____ Anxiety
_____ Suicidal thoughts
_____ Depression
_____ Hallucinations
_____ Nervousness
_____ Other: *Please Specify:* _____

PAST MEDICAL HISTORY

Check all medical conditions you have been treated for in the **PAST**, including all hospitalizations.

_____AIDS/HIV
_____Anemia
_____Angina
_____Arthritis
_____Asthma
_____Benign Tumors
_____Bleeding or clotting disease
_____Bowel Irregularity
_____Bronchitis
_____Cancer: _____

_____Cerebral Aneurysm
_____Chronic Musculoskeletal Pain
_____Chronic Vomiting / Diarrhea
_____COPD (Chronic Obstructive Pulmonary Disease)
_____Coronary Artery Disease
_____Crohn's Disease
_____Current Infections
_____Depression
_____Suicidal Thoughts
_____GI Disorder
_____Gout
_____Headaches
_____Heart Attack
_____Heart Palpitations/murmurs
_____Hepatitis
_____Herniation
_____High Blood Pressure
_____Hyperlipidemia
_____Incontinence
_____Kidney Disease
_____Leukemia
_____Liver Disease
_____Lumbar Disc Disease
_____Lupus
_____Meningitis
_____Mitral Valve Prolapse
_____Diabetes
_____Dizziness or Fainting
_____Heart Rhythm Disturbance
_____Eczema
_____Emphysema
_____Environmental Toxin Exposure
_____Fibromyalgia
_____Gall Bladder Disease
_____Gastroesophogeal reflux
_____Multiple Sclerosis
_____Neuropathy
_____Osteoporosis
_____Parkinson's Disease
_____Pneumonia
_____Previous Injury to Neck or Spine
_____Psychiatric
_____Pulmonary Condition
_____Pyelonephritis
_____Rheumatologic Disorders
_____Seizures / Epilepsy
_____Sexual Dysfunction
_____Sickle Cell Anemia
_____Sleep Disorders
_____Stroke
_____Thyroid

PAST SURGICAL HISTORY

1. Have you ever had any bad reactions to anesthesia? **Y / N** If yes, please elaborate.

   _____

2. Please list all procedures you have had, including dates:

Procedure	Date (year)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NON-WC PAIN QUESTIONNAIRE

SOCIAL HISTORY

Please check all substances that you now use or have used in the past. If you quit, state how long ago.

Substance	How much?	How often?	For how long?	Still use?
Cigarettes	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
*Coffee	_____	_____	_____	_____
*Tea	_____	_____	_____	_____
*Soft Drinks	_____	_____	_____	_____
Street Drugs	_____	_____	_____	_____

**caffeinated only*

1. Are you married? **Y / N** If yes, do you live together? **Y / N**
   a. Spouse's Name: _____
2. Do you have a significant other? **Y / N** If yes, do you live together? **Y / N**
   a. Please provide name: _____
3. Do you have any children? **Y / N** If yes, do they live with you? **Y / N**
   a. How many and please provide ages: _____
4. On a scale of 0-10*(10 being perfect)*, how well do you and your immediate family get along:

   _____
5. Do you have any *blood* relatives who have chronic pain or problems similar to yours? Please explain:_____

   _____

   _____
6. Please give your level of activity at the **PRESENT** time:

   Vocational Activity: (including non-pay or volunteer work)

   _____

   Recreational Activity: _____

   _____

   Social Activity: _____

NON-WC PAIN QUESTIONNAIRE

7. What activities were you able to perform **BEFORE** that you are unable to do now?

   Vocational Activity (including non-pay or volunteer work)

   _____

   Recreational Activity: _____

   _____

   Social Activity: _____

   _____

8. How has the pain affected you emotionally? (i.e. depression, anxiety, fear, etc…)

   _____

   _____

9. What are your biggest worriers when you think about your pain?

   _____

10. Do you have trouble falling asleep at night? **Y/N**

    a. If yes, please explain: _____

    b. What time do you go to bed? _____

    c. What time do you fall asleep? _____

    d. What time do you wake up? _____

    e. Do you feel adequately rested? **Y/N**

11. Do you experience any drowsiness during the day? **Y/N**
    Use the following scale to choose the most appropriate number for each situation:
    - 0 = **NO** chance of dozing
    - 1 = **SLIGHT** chance of dozing
    - 3 = **HIGH** chance of dozing

Situation	Chance Of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

For office use only:

PAIN QUESTIONNAIRE

12. Have you previously been injured in a motor vehicle accident or non-motor vehicle accident?

Y / N If yes, please explain which body-part, when, how, and the outcome of the injury.

_____

_____

_____

13. Have you served in the Military before? **Y / N** If yes, please give dates and describe any injury that you might have suffered. _____

_____

MEDICATIONS

1. What *pain* medications do you **CURRENTLY** take?

Name	Amount	Times per day	Effective?

2. What *pain* medications have you tried in the **PAST**?

Name	Amount	Times per day	Effective?

NON-WC PAIN QUESTIONNAIRE

3. Do you take any aspirin, herbs or any over the counter medications?

_____

_____

_____

_____

4. Please list all medications you have previously had a bad reaction to. Describe briefly.

_____

_____

_____

5. Please list all <u>other</u> medications you are **CURRENTLY** taking for ***<u>any</u>*** medical purposes.

Name	Amount	Times per day	Effective?

6. Are you allergic to any medications? Are you allergic to any seafood or radiological dyes?

_____

_____

ADDITIONAL INFORMATION

1. Other than your primary care physician specified on *page 5*, what additional physicians are treating you at the present time, and would you like them to receive updated information on your treatment?

Physician Name	Specialty	Address	Phone and Fax	Send updates?

2. Please list any additional information which you feel is pertinent and has not been addressed.

_____

_____

_____

_____

_____

Sign: _____

Print Name: _____

Date: _____

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP