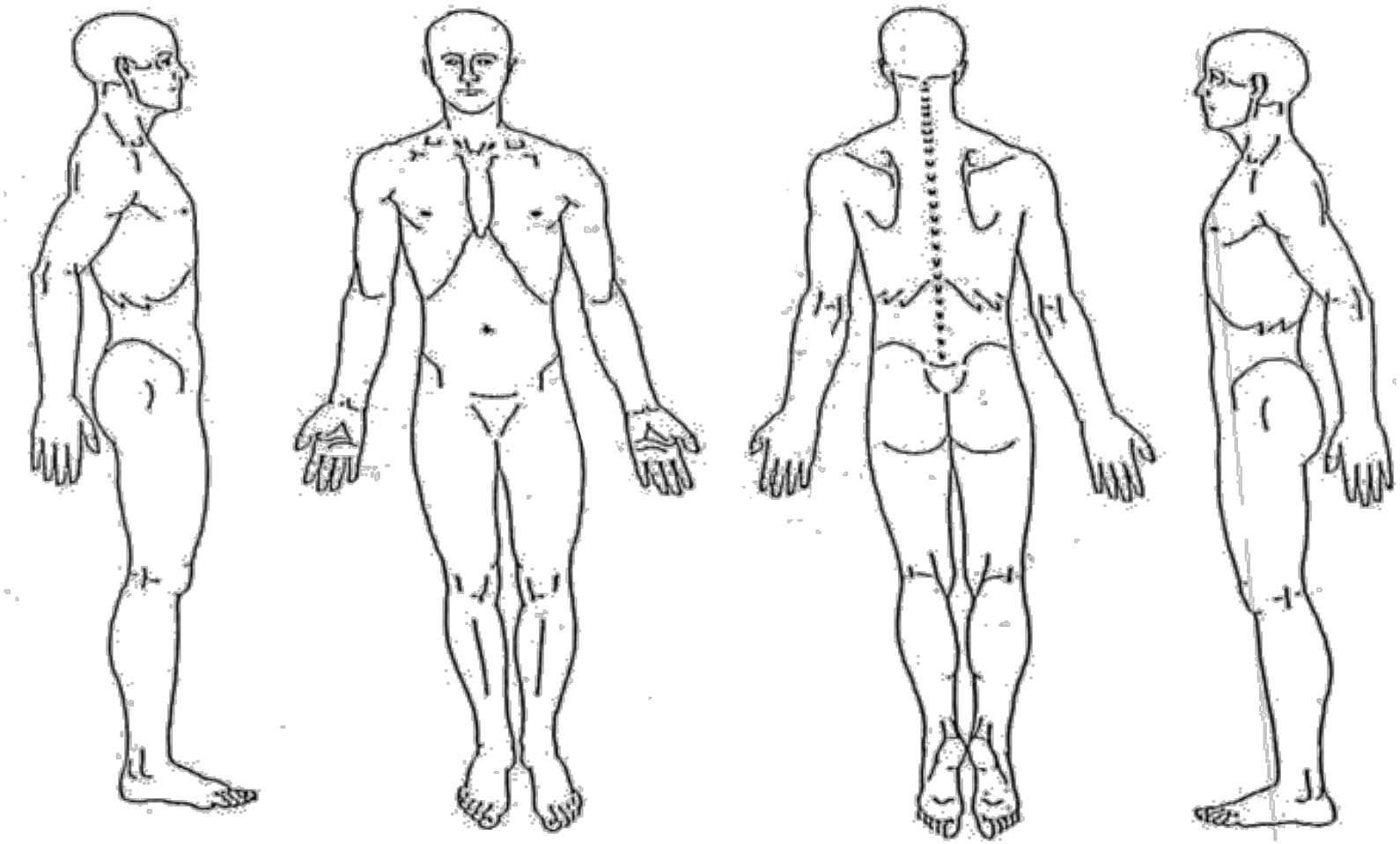
PAIN QUESTIONNAIRE

Patient Name: _____

Patient Date of Birth: _____ 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: _____

Height:_____ Weight:_____

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:

    _____

    _____

    _____

    _____

    _____

PAIN QUESTIONNAIRE

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

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 (*Circle one*: Gained/Lost)** If yes, how much?

_____

_____

PAIN QUESTIONNAIRE

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 care physician?

   Name: _____

   Phone: _____

   Address: _____

   _____

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

PAIN QUESTIONNAIRE

REVIEW OF SYSTEMS

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

_____ Chills
_____ Night sweats
_____ Severe fatigue
_____ Fever
_____ Dizziness
_____ Headaches
_____ Wears contacts
_____ Wears glasses
_____ Blurry vision
_____ Double vision
_____ Lumps in neck
_____ Pain in neck
_____ Difficulty breathing
_____ Cough
_____ Coughing up blood
_____ Wheezing
_____ Difficulty breathing while lying flat
_____ Fainting
_____ Abnormal heartbeat
_____ Chest pain
_____ Constipation
_____ Heartburn
_____ Nausea
_____ Abdominal pain
_____ Black tarry stools
_____ Throwing up blood
_____ Urinary incontinence (wetting yourself)
_____ Blood in urine
_____ Difficulty urinating
_____ Painful urination
_____ Itching of skin
_____ Rash
_____ Yellowing of skin
_____ Balance problems
_____ Poor concentration
_____ Memory loss
_____ Numbness
_____ Seizures
_____ Tremors
_____ Weakness
_____ Excessive bleeding
_____ Blood clots
_____ Anxiety
_____ Depression
_____ Hallucinations
_____ Suicidal thoughts

_____ I am **NOT** currently experiencing any of the above listed signs and/or symptoms.

PAST MEDICAL HISTORY

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

❑ 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: _____

❑ Diabetes: _____

❑ Dizziness or Fainting: _____

❑ Heart Rhythm Disturbance: _____

❑ Eczema: _____

❑ Emphysema: _____

❑ Environmental Toxin Exposure: _____

❑ Fibromyalgia: _____

❑ Gall Bladder Disease: _____

❑ Gastroesophogeal reflux: _____

❑ GI Disorder: _____

❑ Gout: _____

PAIN QUESTIONNAIRE

- ❑ 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: _____
- ❑ 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: _____

PAIN QUESTIONNAIRE

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)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

1. Is there any family history of drug addiction? **Y / N** If yes, please elaborate.

   _____

   _____

   _____

2. Is there any family history of chronic pain? **Y / N** If yes, please elaborate.

   _____

   _____

   _____

3. Do you have any *blood* relatives who have a history of drug addiction? **Y / N** If yes, please elaborate.

   _____

   _____

   _____

4. Do you have any *blood* relatives who have chronic pain or problems similar to yours? **Y / N** If yes, please elaborate.

   _____

   _____

   _____

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 a history of childhood abuse or sexual abuse? **Y / N** If yes, please elaborate.

   _____

   _____

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

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

   _____

   Recreational Activity: _____

   _____

   Social Activity: _____

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**
    If yes, please use the scale to choose the most appropriate number for the situations below:

    - 0 = **NO** chance of dozing
    - 1 = **SLIGHT** chance of dozing
    - 2 = **MODERATE** 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:

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. _____

_____

PAIN QUESTIONNAIRE

MEDICATIONS

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

Name	Amount	Times per day	Effective?

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

Name	Amount	Times per day	Effective?

PAIN QUESTIONNAIRE

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

Name	Amount	Times per day	Effective?

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

_____

_____

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

_____

_____

_____

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

_____

_____

_____

PAIN QUESTIONNAIRE

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 of Birth: _____

Date: _____

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