PAIN QUESTIONNAIRE

Complete and return this form before your arrival for your first appointment. Your answers will help us to understand your pain. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Worker's Compensation Claims).

Last Name _____ First Name _____ MI _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referring Physician _____

PRIOR PAIN PROCEDURES:

Have you previously had any pain procedures, blocks, or injections? **YES** **NO**

If your answer is YES please specify: _____

Why are you seeking treatment? _____

Have you seen another pain doctor? Who? _____

PAIN DURATION: How long have you had your current pain? _____ YEARS _____ MONTHS

ONSET OF PAIN: How did your current pain start?

☐ Injury at work ☐ Motor vehicle accident

☐ Undetermined ☐ Illness, non-injury

Other _____

TIMING OF PAIN: How often do you have your pain? (Please check one)

☐ Constantly (100% of the time) ☐ Intermittently (30% to 60% of the time)

☐ Nearly constantly (60% to 95% of the time) ☐ Occasionally (less than 30% of the time)

PAIN QUALITY: How would you describe the pain?

☐ Burning ☐ Cramping ☐ Pins & Needles ☐ Sharp

☐ Numbness ☐ Shooting ☐ Aching ☐ Throbbing

☐ Pressing ☐ Other _____

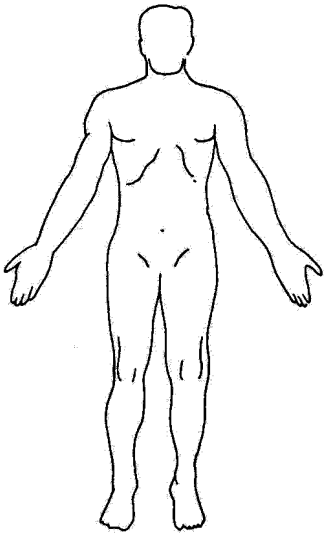
PAIN LEVEL:

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

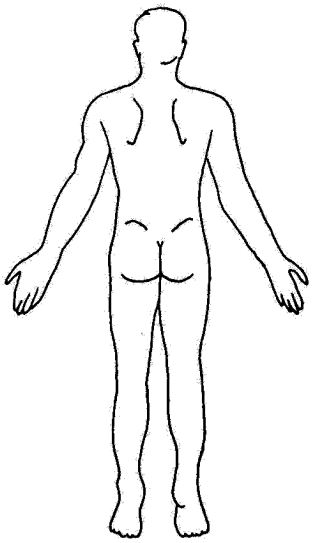
0 1 2 3 4 5 6 7 8 9 10

MILD **MODERATE** **EXTREME**

Patients Name : _____



Front



Back

PAIN LOCATION: Please describe the location(s) of your pain: _____

RELIEVING AND AGGREVATING FACTORS:

How do the following affect your pain? Please check one for each item

	INCREASED	NO CHANGE	DECREASED
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Coughing/Sneezing	☐	☐	☐

How long can you walk before having to stop due to pain? _____ Minutes _____ Hours

How long can you sit before having to get up? _____ Minutes _____ Hours

How long can you stand before you have to sit down? _____ Minutes _____ Hours

Patients Name : _____

PAIN TREATMENTS:

Check all of the treatments you have tried and then indicate the amount of relief if any

	DATE (approx)	No Relief	Moderate Relief	Excellent Relief
Traction		☐	☐	☐
Acupuncture		☐	☐	☐
TENS Unite		☐	☐	☐
Physical Therapy		☐	☐	☐
Heat Treatment		☐	☐	☐
Chiropractic		☐	☐	☐
Exercise		☐	☐	☐

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? If yes, when? _____ YES NO

Have you ever considered suicide? _____ YES NO

EDUCATION: Your highest educational level achieved: _____

EMPLOYMENT: Current employment status (please check all that apply):

☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Unemployed because of the pain

☐ Homemaker ☐ Retired ☐ Student

If you are currently unemployed, indicate how long you have been off work:

☐ 1 - 3 weeks ☐ 4 - 7 months ☐ 12 - 18 months ☐ 25 or more months

☐ 1 - 3 months ☐ 8 - 11 months ☐ 19 - 24 months

LEGAL ISSUES: Indicate any of the following you have filed related to your pain:

☐ Workers' compensation ☐ Social Security Disability Insurance (SSDI)

☐ Personal injury/liability (Unrelated to work) ☐ Other insurance ☐ None

Patients Name : _____

SOCIAL HISTORY:

Marital Status: _____ Lives with _____ Number of children _____

Occupation: _____

Exercise:	YES	NO	Type of exercise		
Tobacco use:	YES	NO	Caffeine use:	YES	NO
Alcohol use:	YES	NO	Contraception?	YES	NO

Ever felt the need to cut down alcohol use?	YES	NO
Ever been angry when criticized about your alcohol use?	YES	NO
Ever felt guilty about something that happened while drinking?	YES	NO
Ever needed an “Eye Opener” in the morning?	YES	NO
Illegal drug use?	YES	NO

SUBSTANCE ABUSE:

Do you have a history of alcoholism?	YES	NO
Have you ever been in a detoxification program for drug abuse?	YES	NO
Alcoholics Anonymous?	YES	NO

FAMILY HISTORY:

Alcoholism	YES	NO	Headaches	YES	NO
Asthma	YES	NO	Heart disease	YES	NO
Bleeding disorders	YES	NO	Hepatitis	YES	NO
CAD/Coronary Disease	YES	NO	Hyperlipidemia	YES	NO
Cancer	YES	NO	Hypertension	YES	NO
COPD /Emphysema	YES	NO	Liver disease	YES	NO
CVA/Stroke	YES	NO	Pain	YES	NO
Diabetes	YES	NO	Pancreatitis	YES	NO
Gout	YES	NO	Pneumonia	YES	NO

ARE YOU CURRENTLY PREGNANT?	YES	NO
ARE YOU TRYING TO BECOME PREGNANT?	YES	NO

YOUR PRIOR MEDICAL HISTORY Patients Name : _____

Infectious disease	YES	NO

Describe _____

Alcoholism	YES	NO	Heart attack	YES	NO
Anemia	YES	NO	Heart disease	YES	NO
Anxiety	YES	NO	Heart murmur	YES	NO
Arthritis	YES	NO	Hemorrhage	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO
Back pain	YES	NO	HIV	YES	NO
Bleed easily	YES	NO	Hyperlipidemia	YES	NO
Blood clots	YES	NO	Hypertension (HTN)	YES	NO
Coronary Disease	YES	NO	IBS/Irritable Bowel	YES	NO
Cancer/tumor	YES	NO	Insomnia	YES	NO
Carotid stenosis	YES	NO	Kidney disease	YES	NO
Carpal Tunnel Syndrome	YES	NO	Liver disease	YES	NO
COPD/Emphysema	YES	NO	Lung disease	YES	NO
Crohn's Disease	YES	NO	Mitral valve regurg	YES	NO
CVA/Stroke	YES	NO	Narcotic addiction	YES	NO
Depression	YES	NO	Nicotine addiction	YES	NO
Diabetes	YES	NO	Pancreatitis	YES	NO
Diverticulitis	YES	NO	Plantar Fasciitis	YES	NO
Edema	YES	NO	Pneumonia	YES	NO
Endometriosis	YES	NO	PVD/Vascular Disease	YES	NO
Epilepsy/seizures	YES	NO	Scoliosis	YES	NO
Fibromyalgia	YES	NO	Shingles	YES	NO
Fracture	YES	NO	Sleep apnea	YES	NO
Gallbladder problems	YES	NO	Thyroid disease	YES	NO
Gastro-intestinal disease	YES	NO	Ulcer	YES	NO
Glaucoma	YES	NO	Urinary Tract Infection	YES	NO
Gout	YES	NO	Yellow Jaundice	YES	NO
Headaches	YES	NO			

Other _____

SURGERIES:

DATE	HOSPITAL	TYPE OF OPERATION

Patients Name : _____

MEDICATIONS: List all current medications, including any over the counter and dietary supplements.

MEDICATION	DOSE	FREQUENCY

ALLERGIES: I am allergic to dye put into my body _____ YES | NO

Other Allergies : _____

_____