**PAIN QUESTIONNAIRE**

Last Name _____ First Name _____ Middle _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ SS# _____

Phone # _____ Weight _____ Height _____

1. Who referred you to us? ☐ Self Other: _____
2. Are you currently pregnant? Yes ( ) No ( ) When was your last menstrual cycle? _____
3. **Circle** what event(s) led to your present pain:

   Cancer Accident or Fall/ Date: _____ Pain following operation No know cause

   Other Problem: _____

   **Describe the Event:** _____

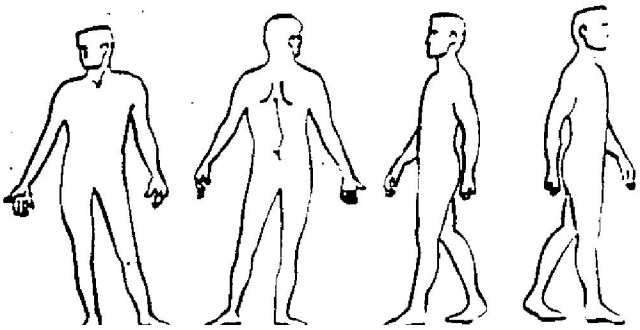
   _____

4. **Circle** the word(s) that best describe your pain:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dull | Shooting | Aching | Throbbing | Cutting | Numbness | Tingling | Stabbing |
| Sore | Heavy | Cramping | Tender | Burning | Pressure | Stinging | Itching |

   Other: _____

5. How long have you had this pain? _____
   Has your pain worsened in the last 6 months? ( ) Yes ( ) No
6. Label the areas that hurt with an X on the diagram below



7. What is your pain level **now**? 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worse pain ever)
   What is your pain level **at its worst**? 0 1 2 3 4 5 6 7 8 9 10
   What is your pain level **at its best**? 0 1 2 3 4 5 6 7 8 9 10

8. Circle how often your pain occurs
   Continuously (nonstop) Several times a day Once or twice a day
   Once or twice a month Less than once a month Rarely

9. **Circle** when your pain is worse: Morning Day Evening Sleep

10. **Circle** when your pain is better: Morning Day Evening Sleep

11. **Circle** what position(s) **INCREASE** your pain: **Same with all positions**
    Sitting Standing Lying Other: _____

12. **Circle** what position(s) **DECREASE** your pain: **Same with all positions**
    Sitting Standing Lying

13. Are there any of these activities that you **CANNOT DO OR HAVE DIFFICULTY DOING** because of your pain? Circle, if any:

    Walk Work Drive Swim Dance Grocery shop Climb stairs
    Dress / undress Family activities Play / Recreation Sex Jog Sleep

14. Do you have trouble falling asleep? ( ) Yes ( ) No How many times do you wake up during the night due to pain? _____

15. **Circle** any you use: Cane Walker Wheelchair Brace Crutches Orthopedic Shoes

16. Please use the following rating scale to indicate your current level of stress.

    0 (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressed)

17. Circle the word(s) that describe(s) how your pain makes you feel: Angry Tense Depressed
    Irritable Scared Sad Nervous Like I want to cry Restless Other _____

    I feel like I have little control over much of what happens to me. ( ) Yes ( ) No

    I don't feel like doing many of the things that I used to do. ( ) Yes ( ) No

    I often feel guilty of burdening others with my problems. ( ) Yes ( ) No

    Do you have thoughts that you would rather not be alive? ( ) Yes ( ) No

18. Does your pain affect **bowel** action? ( ) Yes ( ) No Affect **bladder** action? ( ) Yes ( ) No

19. Have you ever been to a hospital emergency room because of **THIS** pain problem?
    What treatment did you receive? _____

20. Have you ever been admitted to a hospital for **THIS** problem? _____

21. Are you currently working? ( ) Yes ( ) No If yes, indicate ( ) **full** or ( ) **light** duty
    Employer _____ Job _____

22. Do you have any legal action pending related to your pain or health problem? ( ) Yes ( ) No

23. What treatment have you tried for your pain? (Leave blank if NOT tried)

| | | | | | |
|---|---|---|---|---|---|
| ___ Tranquilizers | ___ Helped | ___ No | ___ Pain relievers | ___ Helped | ___ No |
| ___ Surgery | ___ Helped | ___ No | ___ Traction | ___ Helped | ___ No |
| ___ Nerve blocks | ___ Helped | ___ No | ___ Muscle injections | ___ Helped | ___ No |
| ___ Braces or cast | ___ Helped | ___ No | ___ Acupuncture | ___ Helped | ___ No |
| ___ Chiropractic | ___ Helped | ___ No | ___ Massage | ___ Helped | ___ No |
| ___ Physical therapy | ___ Helped | ___ No | ___ Psychotherapy | ___ Helped | ___ No |
| ___ TENS | ___ Helped | ___ No | ___ Biofeedback | ___ Helped | ___ No |
| ___ Relaxation training | ___ Helped | ___ No | ___ Hypnosis | ___ Helped | ___ No |
| ___ Home Exercise | ___ Helped | ___ No | ___ Homeopathy | ___ Helped | ___ No |

Other _____

24. Please indicate which DIAGNOSTIC TESTS you have had for your PAIN:

| | | |
|---|---|---|
| _____ MRI | _____ Bone scan | _____ EKG |
| _____ CAT scan | _____ EMG / Nerve conduction study | _____ Blood work |
| _____ X-ray | _____ Myelogram | _____ |

25. **ALLERGIES** (list all):

26. Please list MEDICATIONS you are **NOW TAKING** (List all prescription or Over-The-Counter):

| Drug | Strength | # of pills per day | Effect on pain |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all medications you have tried in **THE PAST FOR YOUR PAIN**:

| Drug | Maximum Dose Used | Effect on pain |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Circle** any blood thinners you currently take:

Coumadin  Plavix (clopidogrel)  Trental (pentoxifylline)  Ticlid  Asprin

27. **HEALTH HISTORY** (Check if you have a history of any of these health conditions):

**Heart trouble?** ☐ **I do not have any problems with my heart**

| | | |
|---|---|---|
| ___ Heart Disease | ___ Irregular Heart Beat | ___ Heart Attack / Date: _____ |
| ___ Congestive Heart Failure | ___ High Blood Pressure | ___ Pacemaker ___ Angina |

**Lung Problem?** ☐ **I do not have any problems with my lungs**

| | | |
|---|---|---|
| ___ Asthma | ___ Emphysema | ___ Pneumonia / Date: _____ |
| ___ Bronchitis | ___ Sinus Infection | ___ Shortness of Breath |
| ___ Pulmonary Embolus (Blood Clot on lungs) | | |

**Neurological Problems?** ☐ **I do not have any neurological problems**

| | | | |
|---|---|---|---|
| ___ Headaches | ___ Visual Disturbance | ___ Stroke | ___ Memory Loss |
| ___ TIA's | ___ Multiple Sclerosis | ___ Head Injury | |
| ___ Cataracts | ___ Seizures | ___ Dizziness | |

**Musculoskeletal Problems?** ☐ **I do not have any Musculoskeletal problems**

| | | | |
|---|---|---|---|
| ___ Muscle Spasms | ___ Arthritis | ___ Phlebitis | ___ Fibromyalgia |
| ___ Fractures: _____ | | | |

**Digestive Problems?** ☐ **I do not have any digestive problems**

| | | | |
|---|---|---|---|
| ___ Ulcers | ___ Hepatitis | ___ Colitis | ___ Liver Disease |
| ___ Hiatal Hernia | ___ Crohn's | ___ Diverticulosis | |
| ___ Pancreatitis | ___ Gall Bladder | | |

**Endocrine Problems?** ☐ **I do not have any endocrine problems**

| | | |
|---|---|---|
| ___ Diabetes | ___ Hyp**o**thyroid | ___ Kidney Problem |
| ___ Parathyroid Glands | ___ Hyp**er**thyroid | ___ Adrenal Gland |

**Have you ever had cancer? ( ) Yes ( ) No. If yes, where?**

| | | | |
|---|---|---|---|
| ___ Brain | ___ Breast | ___ Lung | ___ Colon |
| ___ Prostate | ___ Rectal | ___ Lymphoma | ___ Leukemia |
| ___ Myeloma | ___ Other | | |

**Cancer Treatment?** ☐ **I have never had any of these treatments**

| | | | |
|---|---|---|---|
| ___ Surgery | _____ Chemotherapy | Radiation | Hormones |
| ___ Other _____ | | | |

28. **WHAT SURGERY / OPERATIONS** have you had? If any, what year? _____

☐ Never had an operation

Surgery / Operation: _____

29. **SOCIAL HISTORY**:

| | | | |
|---|---|---|---|
| Do you smoke? | ( ) Yes ( ) No | # of packs a day? | _____ |
| Alcohol | ( ) Yes ( ) No | How much a day? | _____ |
| Coffee | ( ) Yes ( ) No | How many cups a day? | _____ |
| Recreational/Illegal Drugs | ( ) Yes ( ) No | What type? | _____ |

**Circle one:** Married Divorced Widow Single Separated

Retired ( ) Yes ( ) No

Disabled ( ) Yes ( ) No Who lives with you at home? _____

30. **Have you ever been diagnosed with?** ☐ **I've never had any of these problems**

| | | | |
|---|---|---|---|
| ___ Depression | ___ Anxiety | ___ Paranoid | ___ Psychosis |
| ___ Panic Attacks | ___ Bipolar (Manic/Depressive) | ___ Schizophrenia | |
| ___ Attention Deficit Disorder | ___ Suicide Behavior? ( ) No ( ) Yes, when? _____ | | |