



PAIN MANAGEMENT QUESTIONNAIRE

Name: _____ Date of Birth: _____

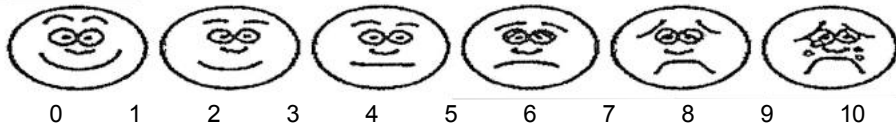
Email: _____ Patient ID: _____ Today's Date: _____

Please answer all questions:

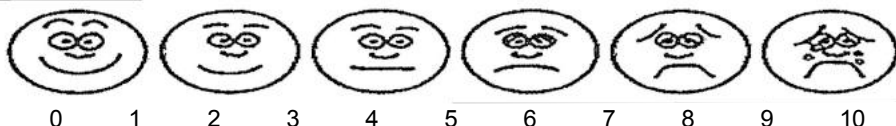
- 1. Where is your pain: _____
2. How long have you had this pain? _____
3. Does your pain shoot or radiate anywhere? NO YES _____
4. Did the pain occur gradually or suddenly? _____ Was it due to an accident? _____
5. Pain is [circle one] Continuous Occasional
6. Is your pain the result of a work related injury? _____
If yes, please advise Front Desk Receptionist immediately to obtain the proper authorization.

- 7. Check the words that MOST describe your pain:
CONSTANT, SHARP, SHOOTING AND THROBBING
CONSTANT, DULL, ACHY
CONSTANT OCCASIONAL DULL, ACHING SHARP SHOOTING
THROBBING BURNING STABBING PRESSURE LIKE TINGLING
NAGGING CRAMPY PINS & NEEDLES TENDER NUMBNESS
ELECTRIC

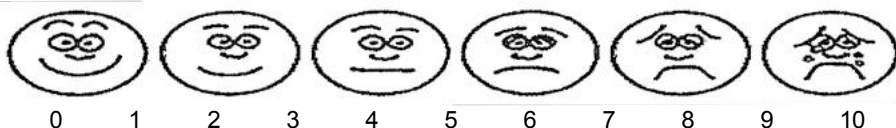
8. What is your level of pain at its WORST:



9. What is your level of pain at the BEST:



10. What is your level of pain NOW:



11. What makes your pain worse: (CHECK ALL THAT APPLY)

- Walking and Increased Activity Prolonged Standing Lying Flat
Sitting Walking Driving
Turning Side to Side Increased Activity Driving
Bending Lifting Movement
Standing Straight Up Going Down Stairs Going Up Stairs
Coughing Sneezing
Turning to the Affected Side Lying on the Affected Side
Morning Night Time

FOR OFFICE USE ONLY

Referring Physician:
Height:
Weight:
Blood Pressure: /
P02:
Heart Rate:
Temp:
LBP: Y N
Allergies:
Pharmacy:
E-Mail Address:

12. What makes your pain better:

- | | | | | |
|--|--|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Lying Down, Resting | <input type="checkbox"/> Lying Flat | <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | <input type="checkbox"/> Resting |
| <input type="checkbox"/> Changing Position | <input type="checkbox"/> Cold | <input type="checkbox"/> Massage | <input type="checkbox"/> Exercise | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Injections | <input type="checkbox"/> Manipulations | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Standing | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Nothing | | | | |

13. Associated symptoms:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Difficulty staying asleep due to pain | <input type="checkbox"/> Feeling blue all the time | |
| <input type="checkbox"/> Frustrated because of pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Legs give out with a feeling of weakness | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Involuntary loss of bowel and bladder | <input type="checkbox"/> Urine Incontinence | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Restrictions on activities | <input type="checkbox"/> Dependence on others for activities | |
| <input type="checkbox"/> Unable to fall asleep | <input type="checkbox"/> Wakes up due to pain at night | |

14. History of falls Yes No

15. Fibromyalgia Yes No

16. Mobility devices Yes No If Yes, what kind: _____

17. Care givers you have visited:

- | | | | |
|---|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Psychiatrist | |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Rheumatologist | |

18. Medicines tried:

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Voltaren gel | <input type="checkbox"/> Lyrica | <input type="checkbox"/> Oxycontin |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Flexeril | <input type="checkbox"/> Toparnax | <input type="checkbox"/> Ms contin |
| <input type="checkbox"/> Mobic | <input type="checkbox"/> Soma | <input type="checkbox"/> Morphine | <input type="checkbox"/> Percocet |
| <input type="checkbox"/> Naproxen | <input type="checkbox"/> Baclofen | <input type="checkbox"/> Methadone | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Zanaflex | <input type="checkbox"/> Fentanyl patch | <input type="checkbox"/> Ultram/Tramadol |
| <input type="checkbox"/> Relafen | <input type="checkbox"/> Robaxin | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Lidoderm patch |
| <input type="checkbox"/> Elavil | <input type="checkbox"/> Neurontin | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Other _____ | | | |

19. Check the treatments you have tried in the past:

- | | | | | |
|---|---|---|--------------------------------------|--|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Epidural injection | <input type="checkbox"/> Sacroiliac injection | <input type="checkbox"/> Massage | <input type="checkbox"/> Facet injection |
| <input type="checkbox"/> Trigger | <input type="checkbox"/> Spinal Cord Stimulator | | <input type="checkbox"/> Tens unit | <input type="checkbox"/> Point injection |
| <input type="checkbox"/> Implanted pump | <input type="checkbox"/> Ice/Heat | <input type="checkbox"/> Brace | <input type="checkbox"/> OTHER _____ | |

20. Have you received psychiatric treatment in the past? NO YES

If so, who was your treating physician? _____

21. Have you had any Spinal surgeries? Type _____ Year? _____

Surgeon: _____

22. Imaging Studies done in the last 12 months:

MRI: Area _____ What Imaging Facility? _____

X-Ray CT Scan: Area _____ What Imaging Facility? _____

EMG Area _____ What Imaging Facility? _____

ALLERGIES:

If more than 5 attach list

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

PAST MEDICAL HISTORY:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> OTHER _____ | | | |

PREVIOUS SURGERIES:

- | | | | | |
|---|---------------------------------------|--|---|--|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart Bypass |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Hip Surgery | <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> Shoulder Surgery | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> OTHER: _____ | |

CURRENT MEDICATIONS:

If more than 5 attach list

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Social History: (Circle all that apply)

- Marital Status:** Single Married Divorced Widowed
- Tobacco Use:** Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoked
- Years Smoking:** _____ **Cigarettes/Packs per day:** _____
- Alcohol Use:** Currently Drinks Alcohol Denies Any Use of Alcohol Quit Drinking Alcohol
- Illicit Substance Abuse:** Currently Using Quit Using Never Used
- Work Status:** Employed Unemployed Disabled Retired Occupation: _____

Family History: (cancer, diabetes, heart disease, bleeding problems, painful conditions, etc.)

_____ Relative: _____

_____ Relative: _____

PLEASE CHECK THE SYMPTOMS OR SIDE EFFECTS YOU ARE HAVING:

GASTROINTESTINAL

- ABDOMINAL PAIN
- NAUSEA OR VOMITING
- BLACK STOOL
- CONSTIPATION
- HEART BURN
- COLITIS
- DIARRHEA

CARDIOVASCULAR

- CHEST PAIN
- FEET SWELLING
- HIGH BLOOD PRESSURE
- IRREGULAR HEART BEAT
- BLOOD CLOTS
- HEART MURMUR

LUNGS

- SHORTNESS OF BREATH
- COPD
- ASTHMA/WHEEZING
- SLEEP APNEA

UROLOGICAL

- LEAKAGE OF URINE
- URINE INCONTINENCE
- KIDNEY STONES
- BLOOD IN URINE
- LOSS OF CONTROL

ENDOCRINE

- DIABETES
- THYROID DISEASE
- ANEMIA
- HEPATITIS

HEAD AND NECK

- HEADACHE
- HEARING LOSS
- SINUS PROBLEMS
- VISUAL PROBLEMS

MUSCLOSKELETAL

- BACK PAIN
- KNEE PAIN
- JOINT PAIN
- MUSCLE CRAMPS
- LEGS GIVE OUT WHEN WALKING
- NECK PAIN
- SHOULDER PAIN
- GOUT
- ARTHRITI

NEUROLOGIC

- DEPRESSION
- PANIC ATTACK
- WEAKNESS
- TROUBLE SLEEPING
- POOR CONCENTRATION
- NUMBNESS AND TINGLING
- ANXIETY
- FATIGUE
- SEIZURES
- INCOORDINATION
- DIFFICULTY THINKING

PLEASE MARK THE AREAS OF YOUR PAINS:

RIGHT

BACK

FRONT

LEFT

