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:**

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

10. **What is your level of pain NOW:**

0 1 2 3 4 5 6 7 8 9 10

11. **What makes your pain worse:** (CHECK ALL THAT APPLY)
    - ❑ Walking and Increased Activity ❑ Prolonged Standing
    - ❑ Sitting ❑ Walking ❑ Lying Flat
    - ❑ Turning Side to Side ❑ Increased Activity Driving ❑ 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:

❑ Lying Down, Resting ❑ Lying Flat ❑ Sitting ❑ Walking ❑ Resting
❑ Changing Position ❑ Cold ❑ Massage ❑ Exercise ❑ Heat
❑ Injections ❑ Manipulations ❑ Physical Therapy ❑ Standing ❑ Medications
❑ Nothing

13. Associated symptoms:

❑ Difficulty staying asleep due to pain ❑ Feeling blue all the time
❑ Frustrated because of pain ❑ Depression ❑ Anxiety ❑ Tingling
❑ Legs give out with a feeling of weakness ❑ Muscle cramps ❑ Weakness ❑ Fatigue
❑ Involuntary loss of bowel and bladder ❑ Urine Incontinence ❑ Numbness
❑ Restrictions on activities ❑ Dependence on others for activities
❑ Unable to fall asleep ❑ 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:

❑ Family Physician ❑ Neurosurgeon ❑ Neurologist ❑ Other _____
❑ Physical therapy ❑ Orthopedic ❑ Psychiatrist
❑ Chiropractor ❑ Podiatrist ❑ Rheumatologist

18. Medicines tried:

❑ Anti-inflammatory ❑ Voltaren gel ❑ Lyrica ❑ Oxycontin
❑ Celebrex ❑ Flexeril ❑ Toparnax ❑ Ms contin
❑ Mobic ❑ Soma ❑ Morphine ❑ Percocet
❑ Naproxen ❑ Baclofen ❑ Methadone ❑ Vicodin
❑ Ibuprofen ❑ Zanaflex ❑ Fentanyl patch ❑ Ultram/Tramadol
❑ Relafen ❑ Robaxin ❑ Marijuana ❑ Lidoderm patch
❑ Elavil ❑ Neurontin ❑ Cocaine ❑ Valium
❑ Other_____

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

❑ Physical therapy ❑ Epidural injection ❑ Sacroiliac injection ❑ Massage ❑ Facet injection
❑ Trigger ❑ Spinal Cord Stimulator ❑ Tens unit ❑ Point injection
❑ Implanted pump ❑ Ice/Heat ❑ Brace ❑ 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:

❑ High Blood Pressure	❑ Diabetes	❑ Heart Disease	❑ Pacemaker
❑ Lung Disease	❑ Liver Problems	❑ Kidney Disease	❑ Thyroid Disease
❑ Depression	❑ Anxiety	❑ Prostate Problems	❑ Cancer
❑ Stroke	❑ Seizure Disorder	❑ Osteoporosis	❑ Stomach Ulcers
❑ Acid Reflux	❑ Glaucoma	❑ HIV	❑ Hepatitis

❑ OTHER _____

PREVIOUS SURGERIES:

❑ Tonsillectomy	❑ Appendectomy	❑ Kidney Stone	❑ Gallbladder	❑ Heart Bypass
❑ Hysterectomy	❑ Hip Surgery	❑ Knee Surgery	❑ Shoulder Surgery	❑ Hernia Repair
❑ Knee Replacement	❑ Eye Surgery	❑ Carpal Tunnel	❑ 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
- ❑ NECK PAIN
- ❑ KNEE PAIN
- ❑ SHOULDER PAIN
- ❑ JOINT PAIN
- ❑ GOUT
- ❑ MUSCLE CRAMPS
- ❑ ARTHRITI
- ❑ LEGS GIVE OUT WHEN WALKING

NEUROLOGIC

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

PLEASE MARK THE AREAS OF YOUR PAINS:

RIGHT **BACK** **FRONT** **LEFT**