



PAIN MANAGEMENT QUESTIONNAIRE

Name: _____ Date of Birth: _____

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

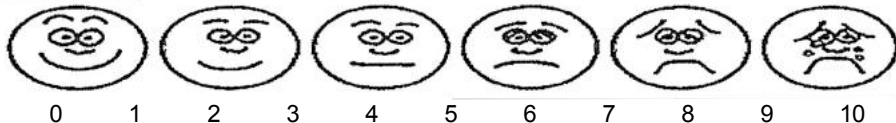
Please answer all questions:

- 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.

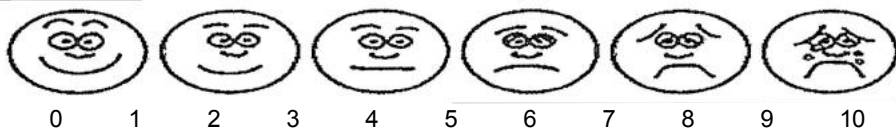
7. Check the words that MOST describe your pain:

- 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

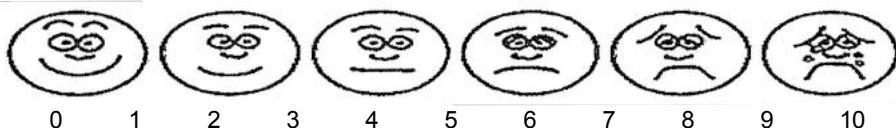
8. What is your level of pain at its WORST:



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
- Movement
- Bending
- Lifting
- Going Up Stairs
- Standing Straight Up
- Going Down Stairs
- Sneezing
- 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

