Texas Pain & Regenerative Medicine

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).

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Phone_____ Fax_____

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? Yes No

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?

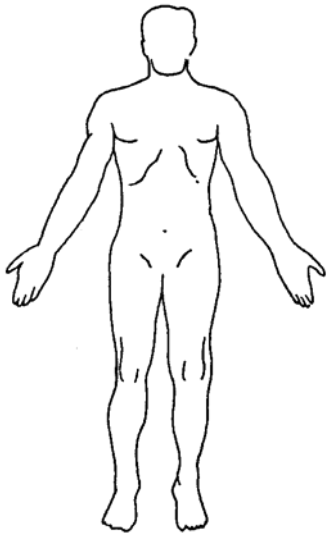
____Burning ____Cramping ____Pins & Needles ____Sharp ____Numbness ____Shooting ____Aching

____Throbbing ____Pressing Other_____

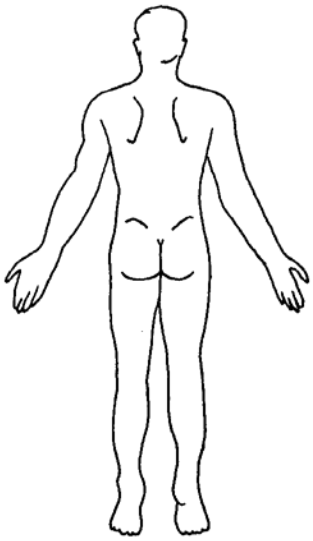
CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

0 1 2 3 4 5 6 7 8 9 10
MILD **MODERATE** **EXTREME**

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



Front



Back

RELIEVING AND AGGREVATING FACTORS: Please check one for each item

How do the following affect your pain?	Increased	No Change	Decreased
Lying down			
Standing			
Sitting			
Walking			
Medications			
Relaxation			
Coughing/Sneezing			

How long can you sit before having to get up? ____Hours ____Minutes

How long can you stand before you have to sit down? ____Hours ____Minutes

Check all the treatments you have tried and then indicate the amount of relief if any and write date of treatment	**No Relief**	**Moderate Relief**	**Excellent Relief**
Traction			
Acupuncture			
TENS Unite			
Physical Therapy			
Heat Treatment			
Chiropractic			

Exercise			

PSYCHOLOGICAL TREATMENT Yes No

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? If yes, when?

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 _____Home maker _____Retired

_____Student

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

____1-3 Weeks ____1-3 Months____4-7 Months ____8-11 Months ____12-8 Months ____19-24 Months

____25 or more Months

LEGAL ISSUES

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

_____ Workers' compensationSocial Security Disability _____ Personal injury/liability (Unrelated to work)

_____Insurance (SSDI) _____ Other Insurance _____None

SOCIAL HISTORY

Marital Status _____ Lives with _____ Number of children _____

Occupation _____

Exercise: Type of exercise	Yes	No
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
Illegal drug use	Yes	No
Ever needed an “Eye Opener” in the morning	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	Hypertension	Yes	No
Headaches	Yes	No	COPD /Emphysema	Yes	No
Headaches	Yes	No	Liver disease	Yes	No
Asthma	Yes	No	CVA/Stroke	Yes	No
Heart disease	Yes	No	Pain	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
Heart disease	Yes	No	Pancreatitis	Yes	No
Bleeding disorders	Yes	No	Gout	Yes	No
CAD/Coronary Disease	Yes	No	Pneumonia	Yes	No
Hepatitis	Yes	No	Cancer	Yes	No
Hyperlipidemia	Yes	No			

ARE YOU CURRENTLY PREGNANT Yes No

ARE YOU TRYING TO BECOME PREGNANT Yes No

YOUR PRIOR MEDICAL HISTORY

Infectious disease, describe_____ Yes No

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

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Crohn's Disease	Yes	No
CVA/Stroke	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Diverticulitis	Yes	No
Edema	Yes	No
Endometriosis	Yes	No
Epilepsy/seizures	Yes	No
Fibromyalgia	Yes	No
Fracture	Yes	No
Gallbladder problems	Yes	No
Gastro-intestinal disease	Yes	No
Glaucoma	Yes	No
Gout	Yes	No
Headaches	Yes	No

Mitral valve regurg	Yes	No
Narcotic addiction	Yes	No
Nicotine addiction	Yes	No
Pancreatitis	Yes	No
Plantar Fasciitis	Yes	No
Pneumonia	Yes	No
PVD/Vascular Disease	Yes	No
Scoliosis	Yes	No
Shingles	Yes	No
Sleep apnea	Yes	No
Thyroid disease	Yes	No
Ulcer	Yes	No
Urinary Tract Infection	Yes	No
Yellow Jaundice	Yes	No
Other_____		

SURGERIES:

DATE	HOSPITAL	TYPE OF OPERATION

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_____