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# SportsMED

Orthopaedic Surgery & Spine Center

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## PAIN QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

1. When (roughly what date) did your present pain start?

\_\_\_\_\_  
Have you ever had similar pain?  
\_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks  
Are you still working?  
 No  Yes Last day on job \_\_\_\_\_

2. How did pain start? (check appropriate box)

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Suddenly  | <input type="checkbox"/> Pulling                  |
| <input type="checkbox"/> Gradually | <input type="checkbox"/> Injured at work          |
| <input type="checkbox"/> Lifting   | <input type="checkbox"/> Injured in auto accident |
| <input type="checkbox"/> Twisting  | <input type="checkbox"/> Hit from behind          |
| <input type="checkbox"/> Fall      | <input type="checkbox"/> Injured during sports    |
| <input type="checkbox"/> Bending   | <input type="checkbox"/> No apparent cause        |

3. What activities make the pain worse?

- |  |   |
|--|---|
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Bending forward  |
| <input type="checkbox"/> Exercise (after)  | <input type="checkbox"/> Bending backward |
| <input type="checkbox"/> Sitting           | <input type="checkbox"/> Coughing         |
| <input type="checkbox"/> Standing          | <input type="checkbox"/> Sneezing         |
| <input type="checkbox"/> Walking           |   |

4. What reduces the pain?

- |   |   |
|---|---|
| <input type="checkbox"/> Lying down                   | <input type="checkbox"/> Pain pills                         |
| <input type="checkbox"/> Sitting                      | <input type="checkbox"/> Injections for pain                |
| <input type="checkbox"/> Standing                     | <input type="checkbox"/> Muscle relaxant pills              |
| <input type="checkbox"/> Walking                      | <input type="checkbox"/> Aspirin or anti-inflammatory pills |
| <input type="checkbox"/> Manipulation                 |   |
| <input type="checkbox"/> Exercise in physical therapy | <input type="checkbox"/> Nothing                            |
|   | <input type="checkbox"/> Other _____                        |

5. Have you had any of these diagnostic studies?

	No	Yes	Date	Location
Diagnostic x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CT (computed topography) scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Myelogram (x-ray with dye injection)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Electromyogram (EMG)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MRI (magnetic resonance imaging)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthrogram or sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

6. Have you been hospitalized for your pain problem?

No  Yes  
Number of times \_\_\_\_\_ Dates \_\_\_\_\_

7. Have you had surgery for this problem?  No  Yes

Number of times \_\_\_\_\_ Dates \_\_\_\_\_  
Name of Surgeon \_\_\_\_\_

8. Do you take blood thinners?  No  Yes  
 Plavix  Coumadin  Pradaxa  
 Aspirin  Vitamin E  Xarelto  
 Other \_\_\_\_\_

9. Do you smoke?  No  Yes How much? \_\_\_\_\_

10. Are you diabetic?  No  Yes

11. Do you have any of the following conditions?

- |   |   |
|---|---|
| <input type="checkbox"/> Stomach problems         | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Heart                  |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Epilepsy               |
| <input type="checkbox"/> Gout                     | <input type="checkbox"/> Weight loss            |
| <input type="checkbox"/> Sexual difficulties      | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Bowel or bladder problem | _____   |

12. Do you have allergies?  No  Yes  
Please list \_\_\_\_\_  
\_\_\_\_\_

13. Are you claustrophobic?  No  Yes

14. Do you have a pacemaker, defibrillator, pain pump or metal in body?  No  Yes

15. Do you drink alcoholic beverages?  No  Yes  
How much? \_\_\_\_\_

16. What other types of doctors or health care providers have you seen for this condition? \_\_\_\_\_  
\_\_\_\_\_

17. Do you have any additional information that would be helpful in understanding your problem? \_\_\_\_\_  
\_\_\_\_\_

18. Please indicate last grade completed in school \_\_\_\_\_

19. To be sure paperwork is filled out correctly, please check if appropriate:

- |   |   |
|---|---|
| <input type="checkbox"/> On workman's compensation  | <input type="checkbox"/> Receiving disability income            |
| <input type="checkbox"/> Report should be sent to referring physician or family physician | <input type="checkbox"/> Legal proceeding pending               |
|   | <input type="checkbox"/> Report should be sent to another party |

Name \_\_\_\_\_  
Address \_\_\_\_\_

20. Do you plan to be at your regular job in 6 months?

No  Yes

OVER

**PATIENT PAIN DRAWING**

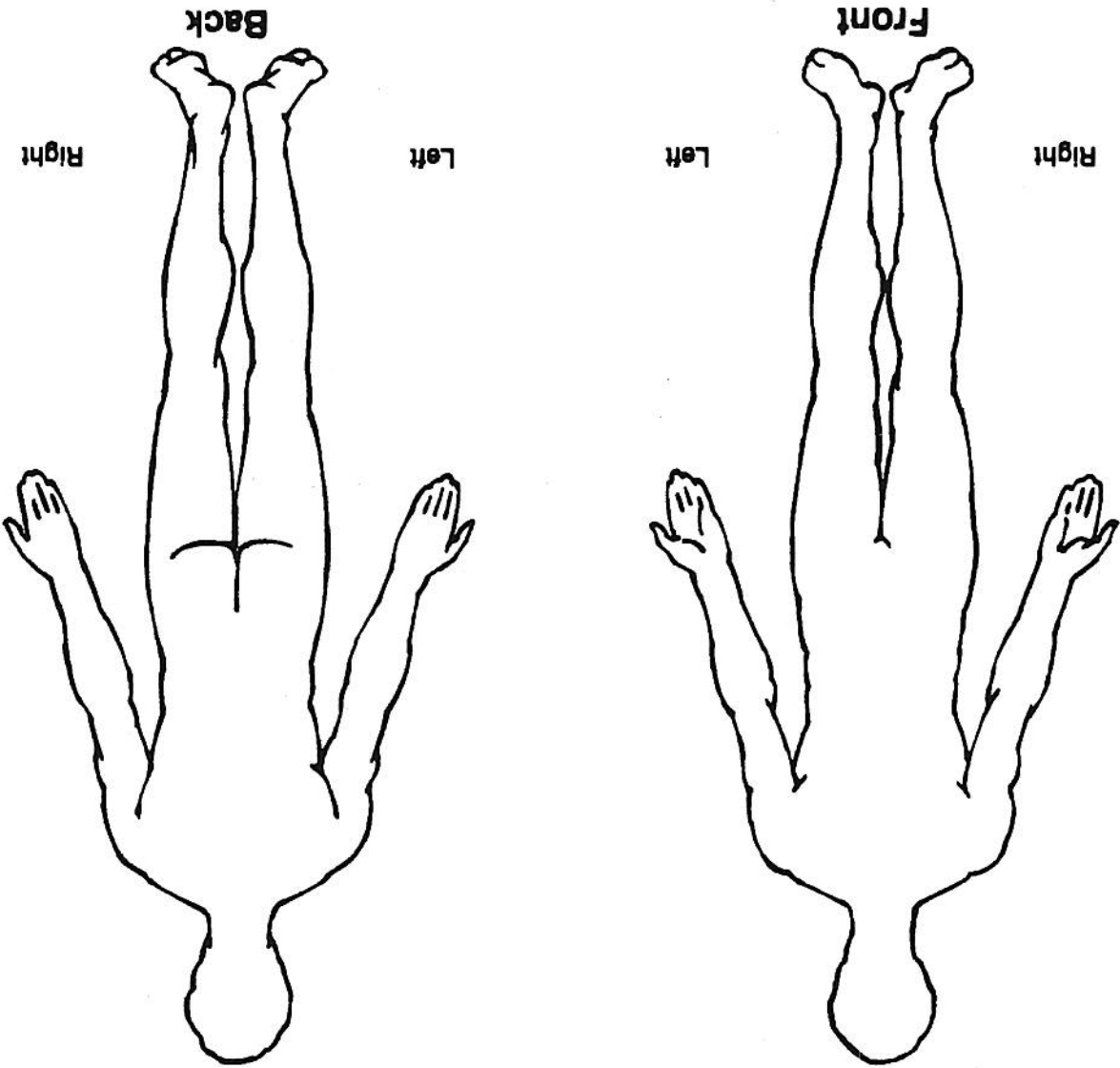
Name \_\_\_\_\_

Date \_\_\_\_\_

**Where is your pain now?**

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

- ▲▲▲ Aching
- === Numbness
- ○ ○ Pins and needles
- XXX Burning
- /// Stabbing



How bad is your pain now?

Please mark with an \* on the body form where the pain is the worst now.

Please mark on the line how bad your pain is now:

On a scale of 1 - 10 with 10 being the worst how would you rate your pain \_\_\_\_\_

No pain \_\_\_\_\_ Worst possible pain \_\_\_\_\_