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PAIN QUESTIONNAIRE

Name: ______________________ Age: _________ Occupation: ____________________ Date: _________

Primary Care Doctor: ____________________________ Referring 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)
   ☐ Suddenly ☐ Pulling
   ☐ Gradually ☐ Injured at work
   ☐ Lifting ☐ Injured in auto accident
   ☐ Twisting ☐ Hit from behind
   ☐ Fall ☐ Injured during sports
   ☐ Bending ☐ No apparent cause

3. What activities make the pain worse?
   ☐ Exercise (during) ☐ Bending forward
   ☐ Exercise (after) ☐ Bending backward
   ☐ Sitting ☐ Coughing
   ☐ Standing ☐ Sneezing
   ☐ Walking

4. What reduces the pain?
   ☐ Lying down ☐ Pain pills
   ☐ Sitting ☐ Injections for pain
   ☐ Standing ☐ Muscle relaxant pills
   ☐ Walking ☐ Aspirin or anti-inflammatory pills
   ☐ Manipulation ☐ Nothing
   ☐ Exercise in physical therapy ☐ Other ______________

5. Have you had any of these diagnostic studies related to your spine or brain?

	No	Yes	Date	Location
Diagnostic x-rays	☐	☐	_____	_________
CT (computed topography) scan	☐	☐	_____	_________
Myelogram (x-ray with dye injection)	☐	☐	_____	_________
Electromyogram (EMG)	☐	☐	_____	_________
Discogram	☐	☐	_____	_________
MRI (magnetic resonance imaging)	☐	☐	_____	_________
Arthrogram or sonogram	☐	☐	_____	_________
Injections	☐	☐	_____	_________

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?
    ☐ Stomach problems ☐ Cancer
    ☐ Diabetes ☐ Heart
    ☐ Arthritis ☐ Epilepsy
    ☐ Gout ☐ Weight loss
    ☐ Sexual difficulties ☐ Other (please explain)
    ☐ 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:
    ☐ On workman's compensation ☐ Receiving disability income
    ☐ Legal proceeding pending
    ☐ Report should be sent to referring physician or family physician ☐ 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

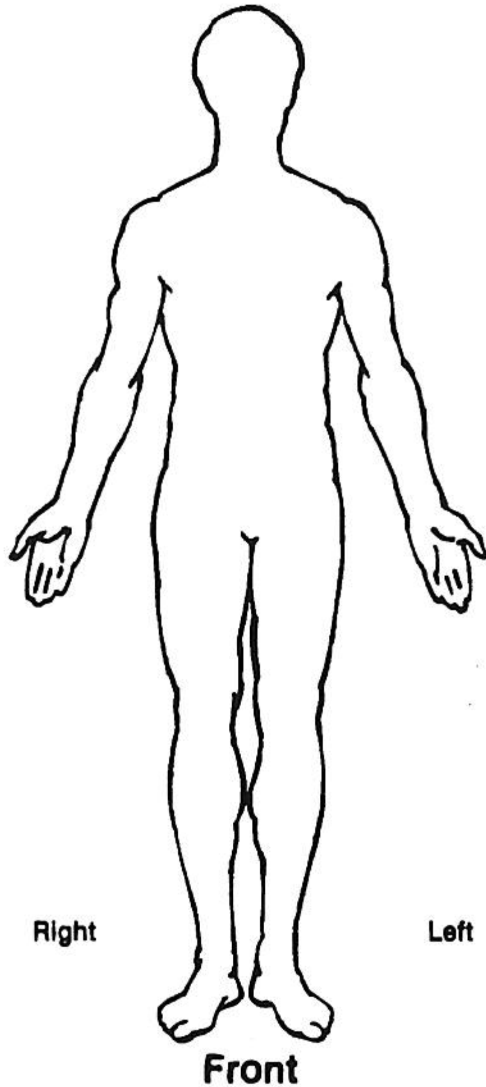
PATIENT PAIN DRAWING

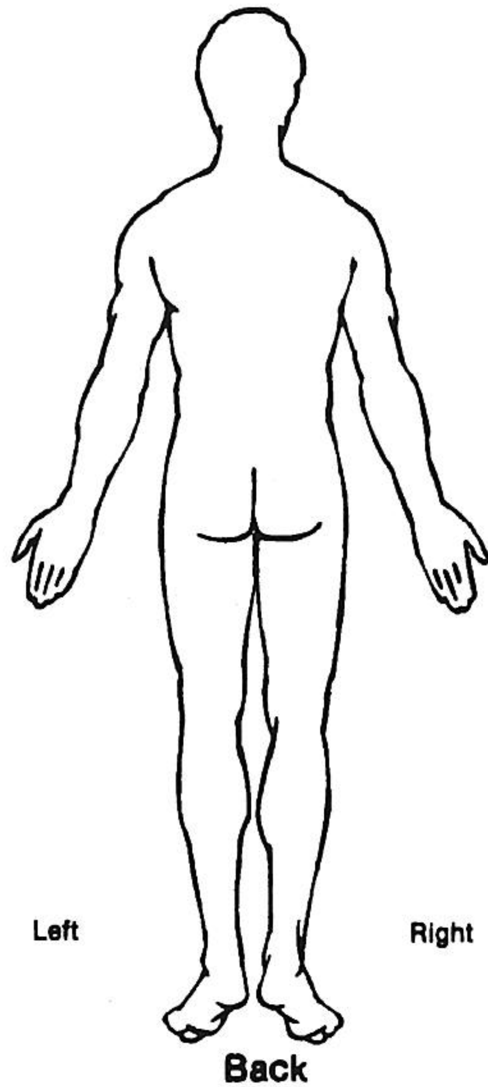
Name ____

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	Burning	Stabbing
▲▲▲	= = =	O O O	X X X	/ / /





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