JAVIER RETO, M.D.

PAIN QUESTIONNAIRE

ACCOUNT ______________________

DATE ______________________

PATIENT NAME ____ DOB ____________________

PRIMARY CARE DOCTOR ____

REFERRING DOCTOR ____

How did pain start ____

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting ☐ Fall ☐ Bending ☐ Pulling
☐ Injured At Work ☐ Injured In Auto Accident ☐ Hit From Behind ☐ Sports

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

Have you ever had similar pain? __________ years __________ months __________ weeks

Are you still working? ☐ Yes ☐ No Last day on job ____________________

Do you take blood thinners? ☐ NO ☐ YES
☐ PLAVIX ☐ COUMADIN ☐ PRADAXA ☐ ASPIRIN ☐ FISH OIL
☐ VITAMIN E ☐ XARELTO ☐ ANTI-INFLAMMATORIES
☐ OTHER____

Are you diabetic? ☐ NO ☐ YES

Do you have a pacemaker, defibrillator, pain pump or metal in body? ☐ NO ☐ YES

Have you had any of these diagnostic studies for your present pain?

DIAGNOSTIC STUDY	NO	YES	DATE	LOCATION
Diagnostic X-rays	☐	☐		
CT Scan	☐	☐		
Electromyogram (EMG)	☐	☐		
Discogram	☐	☐		
MRI	☐	☐		

Have you had any of the following treatments for your present pain? ☐ I HAVE NOT STARTED ANY TREATMENT

TREATMENT	NO	YES	DATE	LOCATION	RELIEF
Physical Therapy	☐	☐			☐ NO ☐ YES
Home Exercises	☐	☐			☐ NO ☐ YES
Chiropractic	☐	☐			☐ NO ☐ YES
Massage	☐	☐			☐ NO ☐ YES
Brace	☐	☐			☐ NO ☐ YES
Acupuncture	☐	☐			☐ NO ☐ YES

Have you had any of the following injections for your present pain?

-----If yes, please list the body part injected and the performing physician. **Please request records to be sent to our office**

Local or Trigger Point Injections (In Office)? ☐ NO ☐ YES ____________________

Epidural Steroid Injection (Performed In Hospital) ☐ NO ☐ YES ____________________

Facet Joint Injection (Performed In Hospital) ☐ NO ☐ YES ____________________

Have you had surgery for this problem?

☐ NO

☐ YES **Please request records to be sent to our office**

Number of times ____________________

Surgeon ______________________________

Dates ______________________________

List any medications you are taking now or have taken for this problem

____
____
____
____

Any additional information regarding your present pain?

Name ______________________________ Date ______________

Please check all that describe your pain.

☐ Burning ☐ Sharp/Stabbing ☐ Tingling ☐ Aching ☐ Throbbing ☐ Shooting ☐ Numbness ☐ Pressure
☐ Pulling/Tearing ☐ Cramping ☐ Other ______________________________

Please check all the appropriate responses in each category to complete the phrase

My pain ☐ interrupts my sleep ☐ is constant ☐ comes and goes

My pain is **worse** ☐ during the day ☐ at night ☐ in the morning ☐ in the afternoon

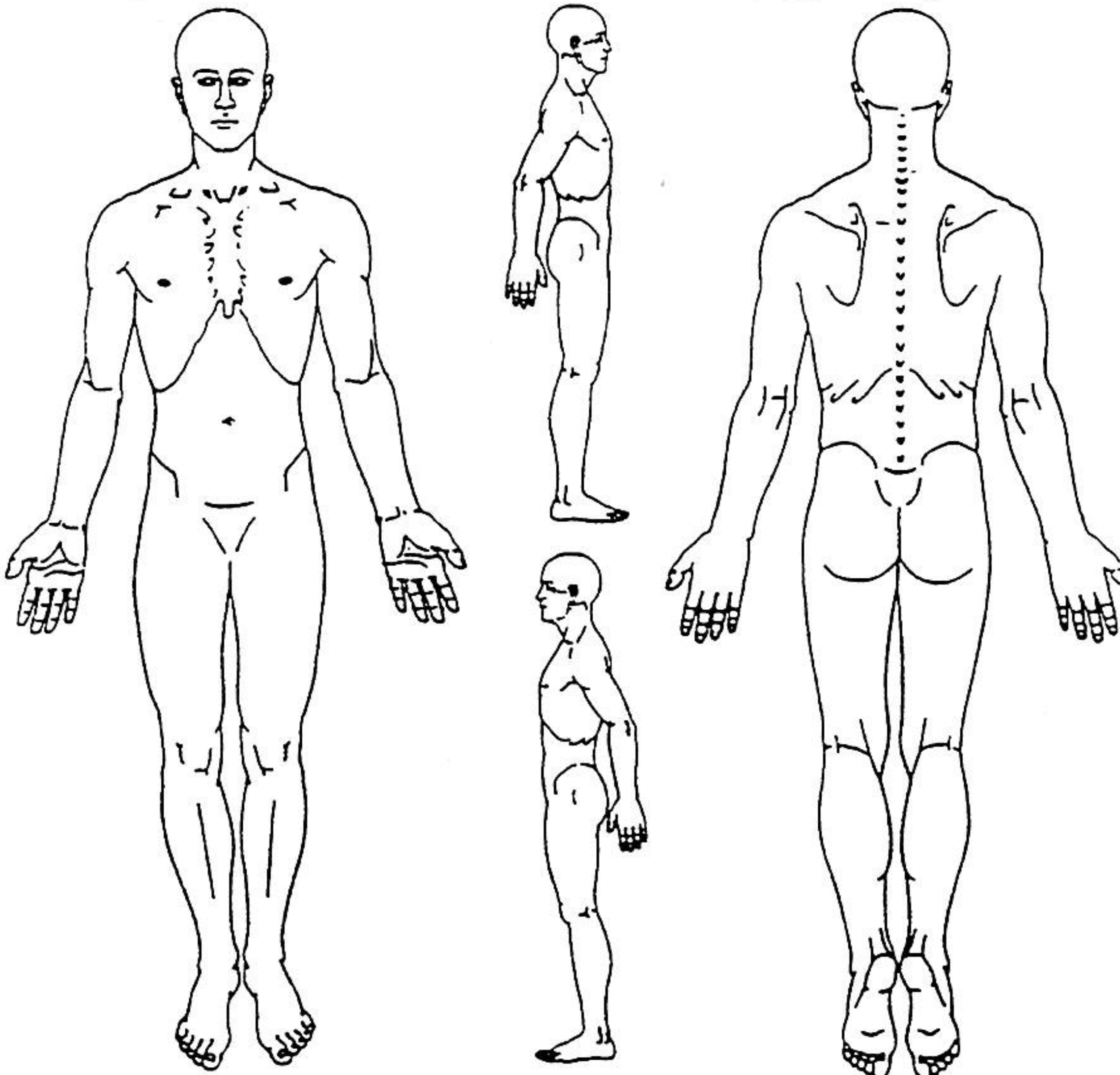
My pain is **worse** when ☐ nothing makes my pain worse
☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Lifting ☐ Driving ☐ Exercise (during) ☐ Exercise (after)
☐ Bending forward ☐ Bending backward ☐ Coughing/Sneezing ☐ Overhead activity
☐ Sports ______________________ ☐ Other ______________________

My pain is **better** when ☐ nothing makes my pain better
☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Lifting ☐ Driving ☐ Exercise (during) ☐ Exercise (after)
☐ Bending forward ☐ Bending backward ☐ Coughing/Sneezing ☐ Overhead activity
☐ Applying heat/ice ☐ Frequently changing positions
☐ Sports ______________________ ☐ Other ______________________

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the correct symbol.
Mark the areas of radiation. Include all affected areas.

◆◆◆ Aching === Numbness OOO Pins/Needles **XXX** Burning /// Stabbing



PAIN SCALE

0 (NO PAIN)
10 (SEVERE ENOUGH TO PASS OUT)

What number would you give your pain **today**?

What number would you give your pain on **average**?

What number would you give your pain at its **worse**?

RETURN PATIENTS

________%
Of relief

Signature ______________________________ Date ______________

Physician reviewed __________ Date ______________________________ Signature