Prime Regenerative and Pain Management
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Pain Questionnaire

The purpose of this questionnaire is to obtain a complete assessment of you and your pain problems. This is a long questionnaire because pain is a very complex problem that affects all aspect of your life. We are trying to evaluate how the pain has affected your life so that we can make the best recommendation possible to assist you in your recovery. This record is confidential and no one can see it without your permission.

Patient's Name:_____ D.O.B.:_____ Age:_____

Date: _____

Signature/Relationship of person completing this form: _____

Patient Address: _____ Phone: (Home): _____

_____ (Cell) _____

_____

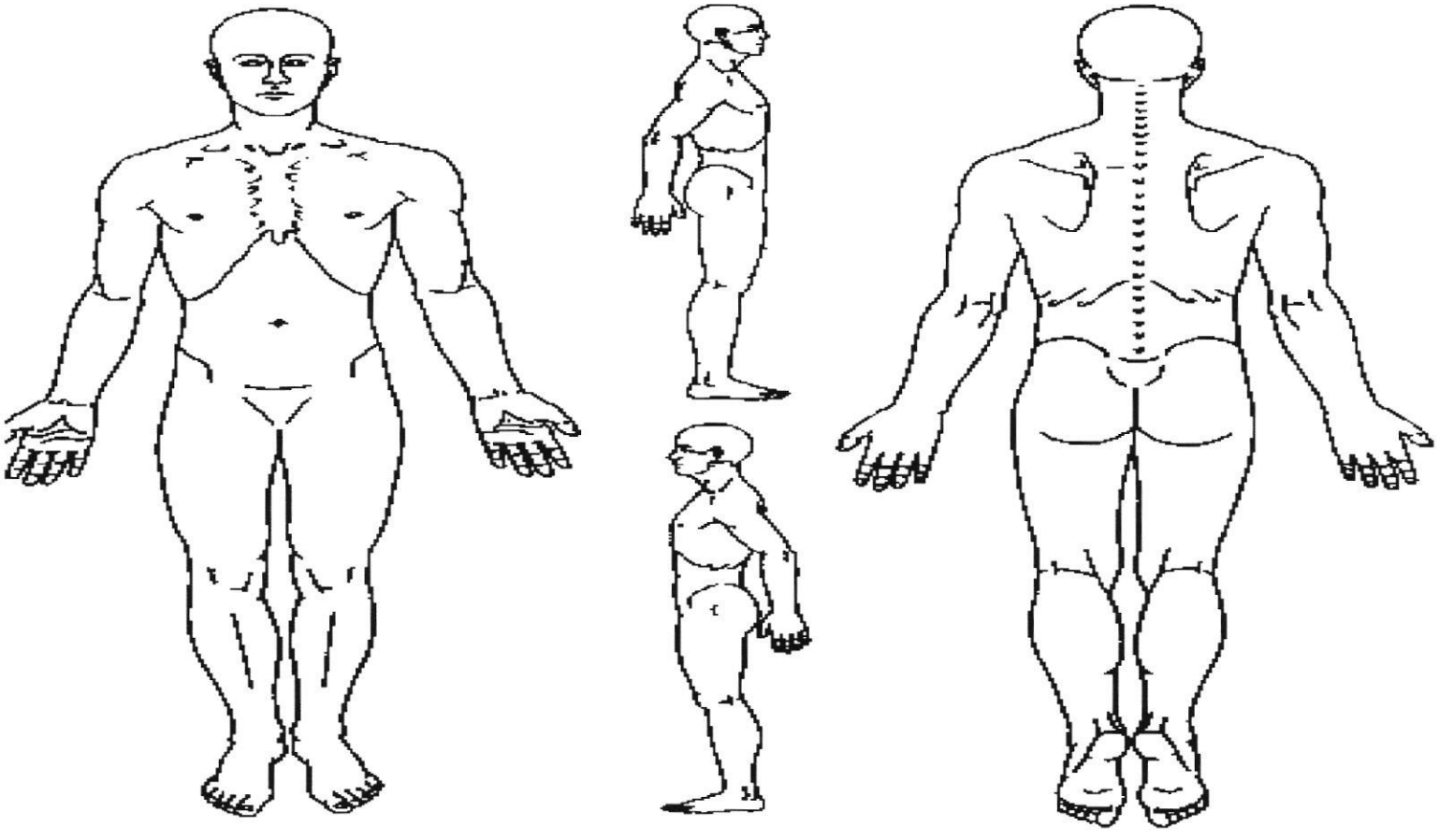
Referring Physician's name and address: _____

Are you currently receiving or in the process of receiving worker's compensation related to your problem? YES NO

Are you involved in litigation related to your pain problem? YES NO

Pain Diagram

Pain: + + + **Numbness: - - -** **Tingling: x x x**



Pain History (Circle ones that apply)	Pain Intensity (Circle the one that applies)
Throbbing, Shooting, Stabbing, Sharp, Cramping, Gnawing, Hot burning, Aching, Numbness, Tingling, Dull, Pulling	0 1 2 3 4 5 6 7 8 9 10 **0**= No Pain **5**= Moderate Pain **10**= Worst Pain Number your pain when it is worst: _____ Number your pain when it is least: _____ Number your pain on average: _____

When did the pain begin?: _____

How did your pain begin?: _____

In general, when is your pain the worst?
Morning _____ Afternoon _____ Evening_____ Night_____ No pattern to the pain_____

How often do you have the pain?
Constantly (100% of time)_____ Nearly constantly(60-95% of time)_____
Intermittent (30-60% of time)_____ Occasionally(less than 30% of time)_____

Please circle what makes your pain feel:
Worse: Walking Lifting Bending Lying Weather changes Standing Other:_____
Better: Heat Ice Rest Lying Weather changes Standing Medication:_____

Prior Treatments (Check all that apply)

	Helpful	Not Helpful
Surgery	☐	☐
Nerve Block	☐	☐
TENS	☐	☐
Physical Therapy	☐	☐
Occupational Therapy	☐	☐
Biofeedback	☐	☐
Psychology support	☐	☐

Diagnostic procedure done

Diagnostic Test	Body part evaluated	Date
Plain X-Rays		
MRI		
CT Scan		
EMG		
Bone Scan		
Discogram		
Myelogram		

Past Medical History

- ☐ Heart Problems_____
- ☐ Hypertension_____
- ☐ Circulation Problems_____
- ☐ Diabetes_____
- ☐ Kidney/Bladder Problems_____
- ☐ Liver Problems_____
- ☐ Cancer_____
- ☐ Blood Disorders_____
- ☐ Lung Problems/Asthma_____
- ☐ Intestinal Problems/Ulcers_____
- ☐ Blackouts/Falls_____
- ☐ Other_____
- ☐ Any medical Devices implanted in your body?_____
  (i.e., pacemaker, portacath, pump, rods, prosthesis, etc.)

Past Surgical History

Name of Surgery	Date

Please list <u>all medication</u> and dosages you are currently taking. PLEASE DO NOT OMIT any blood thinners you may be taking; i.e., Coumadin, Lovenox, Heparin, Plavix, Aggranox, etc.

_____
_____
_____
_____
_____
_____

Please list all drug allergies

_____
_____
_____

Social History

Are you married: Yes/No

Do you take care of other family members: Yes/No If yes, then who?_____

_____

Previous/Current Occupation: _____

Are you currently working? Yes/No If not, why?_____

Do you have any legal issues that are current or pending related to your current medical problem? Yes/No
If yes, please specify_____

Do you smoke? Yes/No If yes, how many per day?_____

Recreational drug use? Yes/No

Alcohol use? Yes/No If yes, how many per day/week_____