Pain Questionnaire

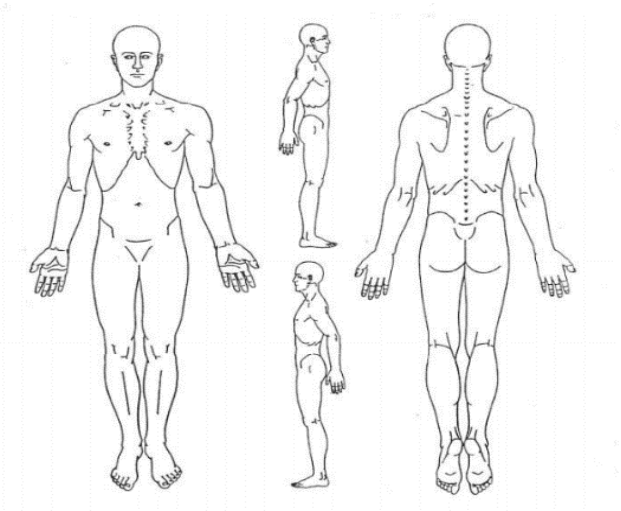
Chief Complaint:
Where is your worst pain?

History of Present Illness:

What is your realistic goal of treatment?

Location of Your Pain:	☐ Neck	☐ Right Arm	☐ Left Arm	☐ Low Back	☐ Right Leg	☐ Left Leg	☐ Whole Body	☐Other
Duration of Your Pain:	Since:							
Onset:	☐ Lifting	☐ Falling	☐ Car Accident	☐ Twisting	☐Unknown	☐ Other		
Onset:	☐ Sudden	☐ Gradual						
Timing:	☐Constant	☐Intermittent	☐Constant Baseline with Intermittent Pain	☐ Worse in AM	☐ Worse in PM	☐ Other		
Quality:	☐ Burning	☐ Electrical	☐ Shooting	☐ Sharp	☐ Aching	☐ Cramping	☐ Other	☐ All
Exacerbated By:	☐ Sitting	☐ Standing	☐ Walking	☐ Bending	☐ Lifting	☐Movement	☐ Weather	☐ All
Relieved By:	☐ Sitting	☐ Standing	☐ Laying	☐ Rest	☐ Heat	☐Medication	☐Injections	☐ Ice
Severity:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10							
Quality of Life:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10							

Please mark your areas of pain on the figure.

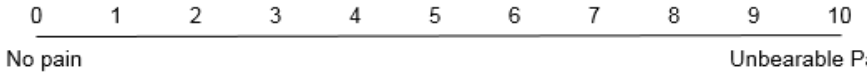


Name:_____

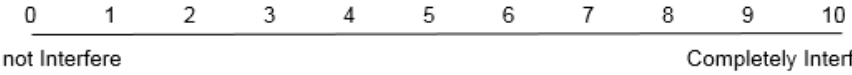
Date:_____DOB:_____

Injections	Previous Treatments	Medications	Surgeries
☐ Epidural Steroid Injection	☐ Physical Therapy	☐ NSAIDs (Motrin, Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, etc.)	☐ Neck Surgery
☐ Radiofrequency Ablation	☐ Chiropractic/Osteopathic Manipulation	☐ Anticonvulsants (Gabapentin, Neurontin, Lyrica, Topamax, Keppra, etc.)	☐ Low Back Surgery
☐ Nerve Blocks	☐ TENS Unit	☐ Antidepressants (Prozac, Zoloft, Celexa, Lexapro, Cymbalta, Effexor, Wellbutrin, etc.)	☐ SCS
☐ Joint Injections	☐ Psych/Cognitive Behavioral Therapy/Biofeedback	☐ Muscle Relaxers (Flexeril, Robaxin, Skelaxin, Soma, Baclofen, Tizanidine, etc.)	☐ Pump
☐ Trigger Point	☐ Braces	☐ Anxiolytics (Xanax, Klonopin, Valium, etc.)	☐ Knee Replacement
☐ Prolotherapy/PRP	☐ Acupuncture/Massage	☐ Topicals (Lidocaine, Lidoderm, Pennsaid, Voltaren Gel, Capsaicin, Compounded Cream, etc.)	☐ Hip Replacement
☐ Intramuscular Steroid Injection	☐ Traction	☐ Opioids (Morphine, Codeine, Hydrocodone, OxyContin, Fentanyl, Duragesic, Tramadol, Nucynta, etc.)	☐ Abdominal Surgeries

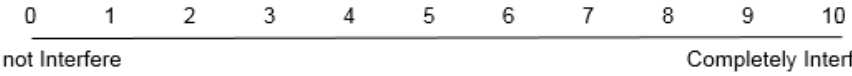
1. What number best describes your pain on average in the past week?



2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?



3. What number best describes how, during the past week, pain has interfered with your general activity?



Past Medical History

Medical Problem	Details

Surgery	Date	Details

Social History:

1. Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed
2. Children: Ages _____
3. Who lives with you at home? _____
4. Use of Alcohol: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily
5. Use of Tobacco (smoke or chew): ☐ Never ☐ Previously ☐ Active at___packs/___cans per day
6. Use of Recreational Drugs (Marijuana, Methamphetamine, Ecstasy, Cocaine)

   ☐ None ☐ Some (Type/Frequency_____)

7. Have you or a family member ever had a problem with dependency or abuse of prescription or non-prescription drugs (including alcohol)?

   If yes, indicate so on the chart.

Type	Family	Personal
Alcohol		
Illegal Drugs		
Prescription Drugs		

8. Have you ever been physically abused? ☐ Yes ☐ No
9. Were you ever sexually abused as a child? ☐ Yes ☐ No
10. Psychological History: Have you ever been diagnosed with any of the following?

Depression	Y|N	Obsessive Compulsive Disorder	Y|N	Bipolar Disorder	Y|N
Suicide Attempt	Y|N	Attention Deficit/Hyperactivity	Y|N	Schizophrenia	Y|N

11. Occupation_____Hours per Day_____What sort of physical activity is involved? _____
    a. Retired: ☐ Yes ☐ No Since when?
    b. Disabled: ☐ Yes ☐ No Since when?
12. Is this a work related injury? ☐ Yes ☐ No
13. Is Worker's Compensation involved? ☐ Yes ☐ No

    If so, date of injury? MM/DD/YYY _____
14. Are you pregnant? ☐ Yes ☐ No

Medications:

Drug Allergies:

Review of Symptoms:

Constitutional:	☐ Night Sweats	☐ Fevers	☐ Chills	☐ Weight Loss	☐ Weight Gain
Head:	☐ Head Trauma		☐ Headache		
Eyes:	☐ Change in Vision		☐ Eye Pain	☐ Excess Tearing	
ENT:	☐ Changes in Hearing		☐ Changes in Smell	☐ Changes in Swallowing	
Neck	☐ Pain	☐ Decreased Range of Motion			
Respiratory:	☐ Cough	☐ Wheezing		☐ Shortness of Breath	☐ Coughing Up Blood
Cardio:	☐ Chest Pain		☐ Palpitations	☐ Shortness of breath on exertion	
GI:	☐ Nausea	☐ Vomiting	☐ Constipation	☐ Diarrhea	☐ Black or Bloody Stool
GU:	☐ Incontinence		☐ Difficulty Urinating	☐ Having to Urinate Frequently	
Muscles, Bones, Ligaments:	☐ Pain	☐ Arthritis	☐ Joint Swelling	☐ Decreased Range of Motion	
Neuro:	☐ Seizures	☐ Syncope		☐ Memory Problems	☐ Dizziness
Skin:	☐ Itching	☐ Ulcers	☐ Rashes	☐ Changes in Hair or Nails	
Psych:	☐ Changes in Mood		☐ Hallucinations	☐ Thoughts of Self Harm	
Endo:	☐ Abnormal Menstrual Cycles		☐ Sexual Difficulty	☐ Heat and Cold Intolerance	
Heme:	☐ Easy Bruising or Bleeding				
Allergy:	☐ Foods	☐ Animals	☐ Insect	☐ Materials	