NEW JERSEY PAIN MANAGEMENT
Spine, Sports & Pain Medicine Center

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Patient Name: _____ DOB: _____ Date: _____

Pain Localization

☐ Y Lower back pain	☐ Y Abdominal pain
☐ Y Neck pain	☐ Y chest pain or discomfort
☐ Y Headache	☐ Y pelvic pain
☐ Y Generalized pain	☐ Y midback pain
☐ Y Limb pain	☐ Y pain in the tailbone
☐ Y Skull pain	☐ Y pain in the arms
☐ Y Muscle aches	☐ Y Facial pain
☐ Y Bone pain	

Pain Modifiers

Moderates pain	Relieves	Worsens	Unchanged
Lying down	☐ Y	☐ Y	☐ Y
Standing	☐ Y	☐ Y	☐ Y
Sitting	☐ Y	☐ Y	☐ Y
Walking	☐ Y	☐ Y	☐ Y
Exercise	☐ Y	☐ Y	☐ Y
Medications	☐ Y	☐ Y	☐ Y
Relaxation	☐ Y	☐ Y	☐ Y
Think about something else	☐ Y	☐ Y	☐ Y
Coughing/Sneezing	☐ Y	☐ Y	☐ Y
Urination	☐ Y	☐ Y	☐ Y
Bowel Movement	☐ Y	☐ Y	☐ Y

Activity tolerance

- Unable to walk for more than (ft)
- Unable to sit for more than (min)
- Unable to stand for more than (min)

Lie down during the day due to pain:

- ☐ Y Never
- ☐ Y Seldom
- ☐ Y Sometimes
- ☐ Y Often
- ☐ Y Constantly

Activities avoided during past month due to pain

- ☐ Y Work
- ☐ Y Yard work/shopping
- ☐ Y Recreation
- ☐ Y Exercise
- ☐ Y Housework
- ☐ Y Socializing
- ☐ Y Sexual activity
- ☐ Y Driving
- ☐ Y Self-care

Misc. Symptoms

- ☐ Y tingling of the legs
- ☐ Y lightning pains
- ☐ Y Burning in right leg or foot
- ☐ Y Burning in left leg or foot
- ☐ Y Buttock pain radiating back of leg
- ☐ Y leg weakness
- ☐ Y abnormality of walk
- ☐ Y changes in urinary habits
- ☐ Y Change in bowel movement frequency
- ☐ Y unable to restrain bowel movement
- ☐ Y joint pain, localized in the hip

Pain Intensity (scale 0-10)

- Current Pain Level ___(0-10)
- Average Pain last 7 days Level ___(0-10)
- Best Pain in last 7 days Level___(0-10)
- Worst Pain in last 7 days Level ___(0-10)

Timing of Pain

- ☐ Y Constant (100% of the time)
- ☐ Y Frequent (75% of the time)
- ☐ Y Intermittent (50% of the time)
- ☐ Y Occasional (25% of the time)

Pain Quality

☐ Y Burning	☐ Y Pressure like
☐ Y Throbbing	☐ Y Lightening like
☐ Y Dull, aching	☐ Y Electric like
☐ Y Shooting	☐ Y Cutting
☐ Y Sharp	☐ Y Numbness
☐ Y Cramping	☐ Y Tingling

- Has your personal information *(insurance, address, phone number or emergency contact)* changed since your last visit? **YES or NO**

- Has your medical history *(medications, hospitalizations or illnesses)* changed since your last visit? ? **YES or NO**