Comprehensive Pain Management
Patient Pain Questionnaire

The purpose of this questionnaire is to obtain a complete assessment of you and your pain problem. This is a long questionnaire because pain is a very complex problem that affects all of your life. Past experiences and attitudes are important in understanding present behaviors and feelings. We are trying to evaluate how the pain has affected and changed you as a person 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.

Background Information

Patient's name _____

Signature/ Relationship of person Completing Form _____

Patient Address _____

Phone (home)_____(work) _____

Date of Birth_____ Male/Female

Height_____Weight _____

Occupation _____

Referring Physician's Name_____Phone _____

Whom may we thank for referring you (if not physician)? _____

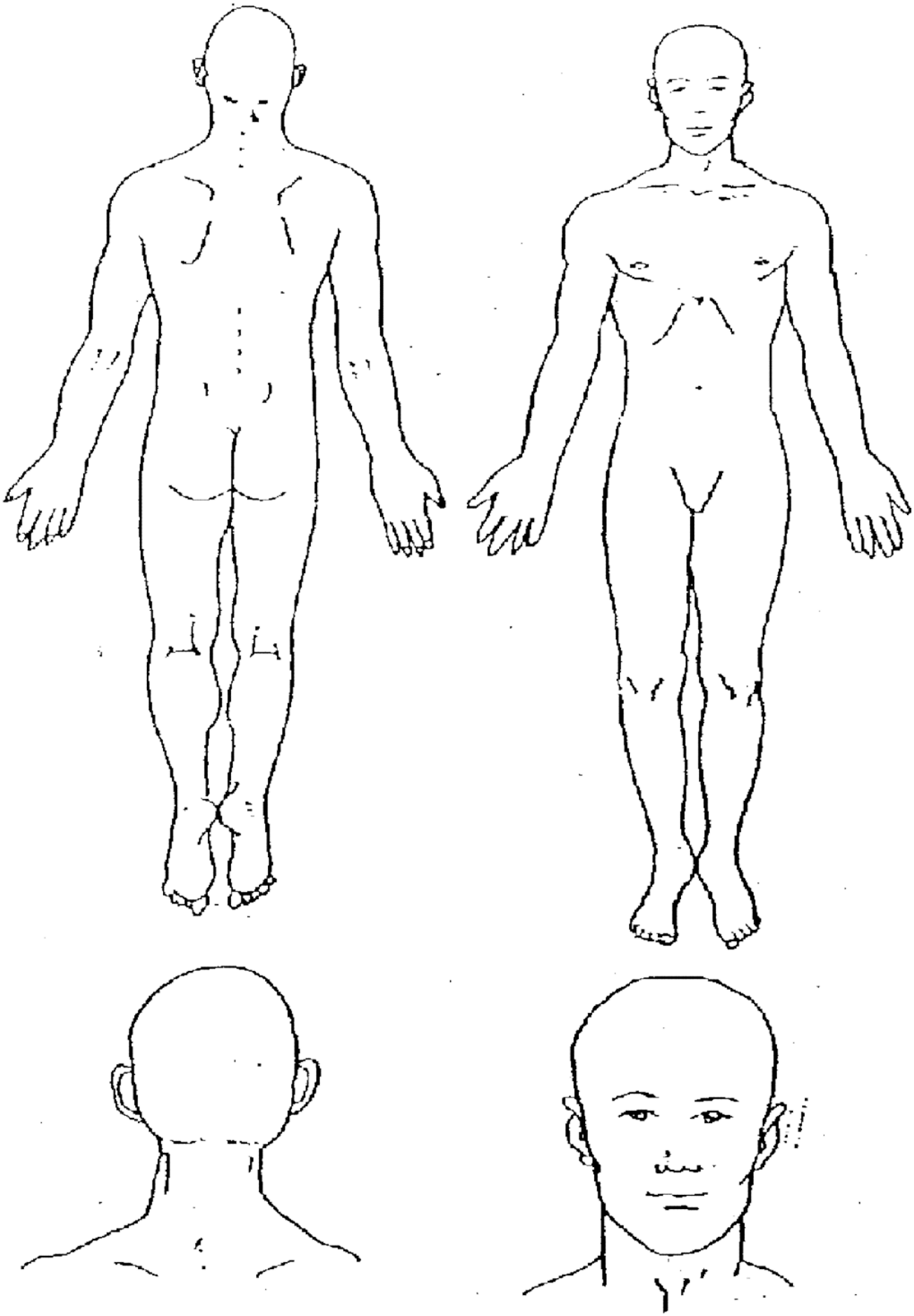
Referring Physician's Address _____

Are you currently receiving workers compensation related to your pain problem? Yes No

Are you involved with litigation related to your pain problem? Yes No

Pain Diagram

Mark the location(s) of your pain on the body outlines below.



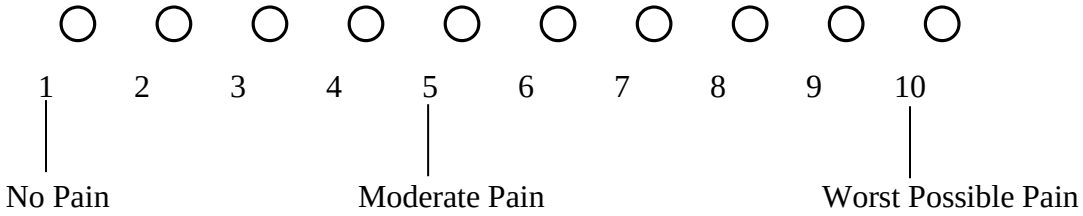
Pain History

Read each of the types of pains below. Put a check next to all that apply and list the corresponding location on your body.

Type of Pain	Check If Apply	Location
Throbbing		
Shooting		
Stabbing		
Sharp		
Cramping		
Gnawing		
Hot-Burning		
Aching		
Numbness		
Tingling		
Dull		
Pulling		
Others		

Pain Intensity

Please Mark your pain level at the present time



Which of the following best describes your usual level of pain?

Mild	Uncomfortable	Distressing/ Severe	Very Severe	Unbearable
_____	_____	_____	_____	_____

Please rate your pain intensity on a scale from 0 = no pain to 10 = excruciating, incapacitating, worst pain possible.

Write the number in the spaces below:

a. Describes your pain at its worst _____
b. Describes your pain when its least _____
c. Describes your pain on the average _____

When, and how, did your pain begin?

_____

_____

_____

_____

_____

Please briefly describe the circumstances of when your pain began.

_____

_____

_____

_____

In general when is your pain the worst? (Please check your answer)

Morning_____Afternoon_____Evening_____Night_____No pattern to the pain _____

How often do you have your pain? (Please check one)

Constantly (100% of the time)_____ Nearly Constantly (60-95%) _____

Intermittently (30-59% of the time)_____ Occasionally (less than 30% of the time) _____

Please check what makes your pain feel:

Worse	Better
☐Walking/Exercise	☐Heat
☐Lifting	☐Ice
☐Bending	☐Rest
☐Lying	☐Lying
☐Weather/Temperature change	☐Weather Temperature change
☐Standing	☐Standing
☐Other: _____	☐Medication: _____
	☐Other: _____

Activity

During the past month, how much did the pain interfere with the following activities? (Circle the number for each question)

Activity	Not at all	A little bit	Moderately	Quite a bit	Extremely
Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Yard work or shopping	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Recreation and hobbies	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Physical exercise	1	2	3	4	5
Sleep	1	2	3	4	5
Appetite	1	2	3	4	5

Pain History

List all of the doctors/clinicians and their specialists that have been involved in the treatment of your pain. List approximate dates of treatment.

Doctor/Clinician	Specialty	Dates of Treatment

Prior Treatments (check all that apply)

	Helpful	Not Helpful
Surgery	☐	☐
Nerve Block	☐	☐
TENS/MENS	☐	☐
Physical Therapy	☐	☐
Occupational Therapy	☐	☐
Biofeedback/Relaxation Therapy	☐	☐
Professional Phsychological Support	☐	☐
Other:	☐	☐

Please complete the boxes for diagnostic procedures you have had to evaluate your pain problem.

Diagnostic Test	Body Part Evaluated	Date
Plain X-Rays		
MRI		
EMG		
Nerve Conduction Velocity		
Myelogram		
CT Scan		
Bone Scan		
Discogram		
Other		

Please list all medication that you currently use. (Include prescribed, over the counter, and herbal remedies.)

Current Medications Dose Frequency Date Started Efficacy(pain meds) Side Effects

Please list all drug allergies and specify reaction.

Medical History

Do you, or have you had:

	Date Diagnosed
☐Heart Problems	_____
☐Hypertension	_____
☐Circulation problems	_____
☐Diabetes	_____
☐Kidney/Bladder problems	_____
☐Liver Problems	_____
☐Cancer	_____
☐Blood disorders	_____
☐Lung problems/Asthma	_____
☐Intestinal problems/Ulcers	_____
☐Blackout/Falls	_____
☐Other: _____	_____

Past Surgeries

Name of Surgery	Date

Do you have any medical devices implanted in your body?
(i.e. pacemaker, portacath, pump, rods, prosthesis, etc) Yes No

Type of device planted _____

Review of Systems

Check all that you have experienced yourself;

Constitutional:
Wt. _____ Ht. _____ ☐Fever/Chills ☐Night sweats

☐ Weight loss (past year)_____lb ☐Weight gain (past year)_____lb

HEENT
☐Hearing loss ☐Hearing aid: R / L ☐Sinus Problem ☐Loose Teeth

Endocrine
☐Diabetes ☐Insulin Dependent ☐Oral Diabetic Medication
☐Hypothyroidism ☐Hyperthyroidism ☐Addison's Disease
☐Excessive thirst or urination ☐Awaken to urinate

Respiratory
☐Blood ☐COPD ☐Emphysema ☐Asthma
☐Shortness of breath ☐Chronic Cough ☐Cough Secretions Regularly
☐Snoring ☐Home Oxygen ☐Airway Obstruction ☐History of TB
☐Sleep Apnea ☐Nasal Septal Deviation ☐Home breathing Treatment

Cardiovascular
☐Hypertension ☐Angina: Last Episode___/___/___ ☐Palpitations

☐Heart Murmur Yes / No If yes, Do you take antibiotics for dental work. Yes / No
☐Heart Attack: When _/___/___ ☐Chronic Heart Failure ☐Shunts/Stents
☐Rheumatic fever ☐Pacemaker ☐Artificial Valve ☐Coronary Artery Disease

Gastrointestinal
☐Change in appetite ☐History of Hepatitis _____
☐Liver Disease ☐History of Ulcer ☐Heartburn ☐Diarrhea
☐Constipation ☐Gallbladder Disease ☐Nausea/Vomiting ☐Ostomy
☐Signs of GI Bleeding (blood in stool, dark/tarry stool, vomiting blood) _____
☐Bowel incontinence

Gynecological
☐Last Period _____ ☐Menopausal ☐Hysterectomy

Genitourinary
☐Kidney Problem ☐Burning while urinating ☐Blood in Urine ☐Frequency
☐Bladder or Kidney Infections ☐Ostomy ☐Dialysis ☐Catheter
☐Difficulty urinating ☐Urinary incontinence

Neurological

☐Dizziness ☐Headaches ☐Seizures: Last seizure____/____/____

☐Stroke When____/____/____ ☐Weakness of extremities _____

☐Fainting ☐Numbness _____ ☐Paralysis ☐Multiple Sclerosis

☐Other _____

Hematological

☐Easy Bruising ☐Low platelets ☐On aspirin/non-steroidal anti-inflammation

☐History of cancer_____ ☐History of Radiation Therapy

☐History of Chemotherapy ☐On coumadin, lovenox, or other blood thinner

Musculoskeletal

☐Back Pain ☐Arthritis ☐Cast ☐Osteoporosis ☐Amputation

☐Neck Pain ☐Joint Replacement _____ ☐Artificial Limb _____

☐Joint Pain ☐Rheumatoid arthritis

Skin

☐Sores ☐Rash ☐Bruises ☐Cuts ☐Burns

☐Incision ☐Itching

Psychological

During the past month have you been tense or anxious? (Please circle one)

Never Seldom Sometimes Frequently Always

During the past month have you been depressed or discouraged?

Never Seldom Sometimes Frequently Always

During the past month have you been irritable or upset?

Never Seldom Sometimes Frequently Always

When you are in pain, how often is your husband/wife/other family member supportive or encouraging?

Never Seldom Sometimes Frequently Always

When you are in pain, how often does your husband/wife/other family member ignore you or become angry?

Never Seldom Sometimes Frequently Always

Social History

Significant other: _____

Relationship: _____ Phone: _____

Do you take care of other family members? (i.e. parents, children, etc…) Yes No

Previous/Current Occupation: _____

Are you currently working? Yes No If no, why? _____

Tobacco use? Yes No Per Day:_____ No. Years: _____

Recreational drug use? Yes No

How much Beer/Wine/Liquor used per week? _____

Residence (circle one)

A) House Apartment Other: _____

B) Lives Alone Lives with_____# of people

C) Steps to climb (#) _____

Highest education level completed _____

Family History

Do you have a family history of any of the following?

Pain:	Yes	No	Psychological Problems:	Yes	No
Arthritis	Yes	No	Bleeding Disorders:	Yes	No
Cancer	Yes	No	Other: _____		

Expectation of Treatment

As a result of my treatment, I expect: (circle all that apply)

Complete pain relief To be able to do more everyday

Household or yard activities Go back to my usual job

To do more sports, go biking, or go for long walks

What other results do you expect from treatment?

_____

_____

_____

_____

How do you learn best? (printed material, video, discussion, etc.)

_____

_____