



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)? _____

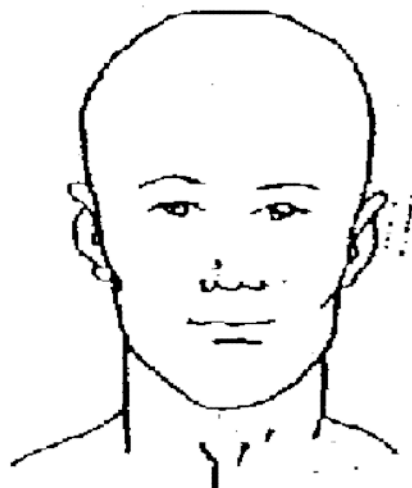
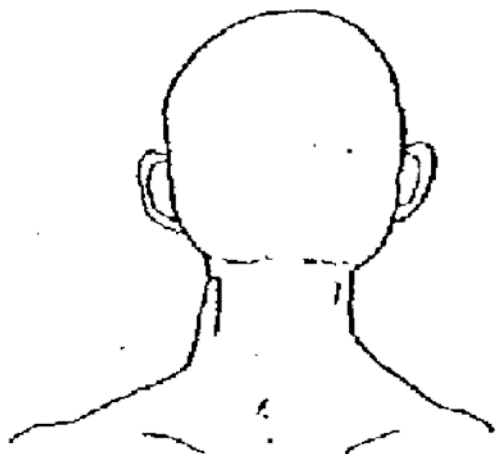
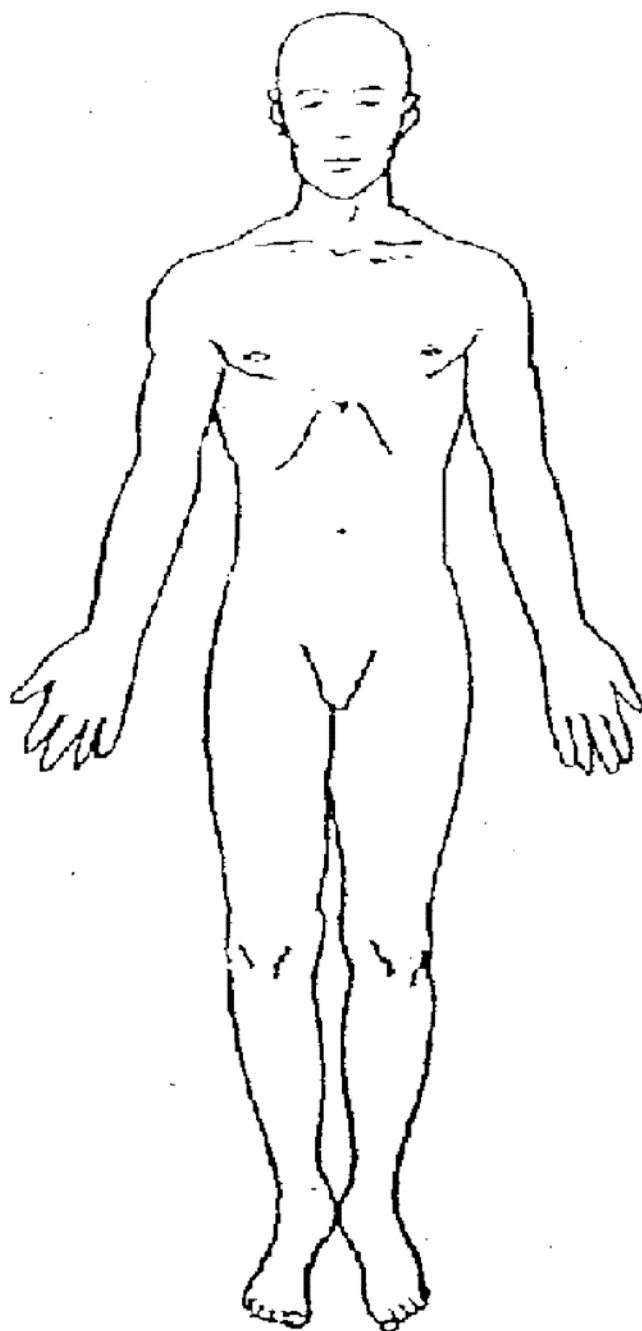
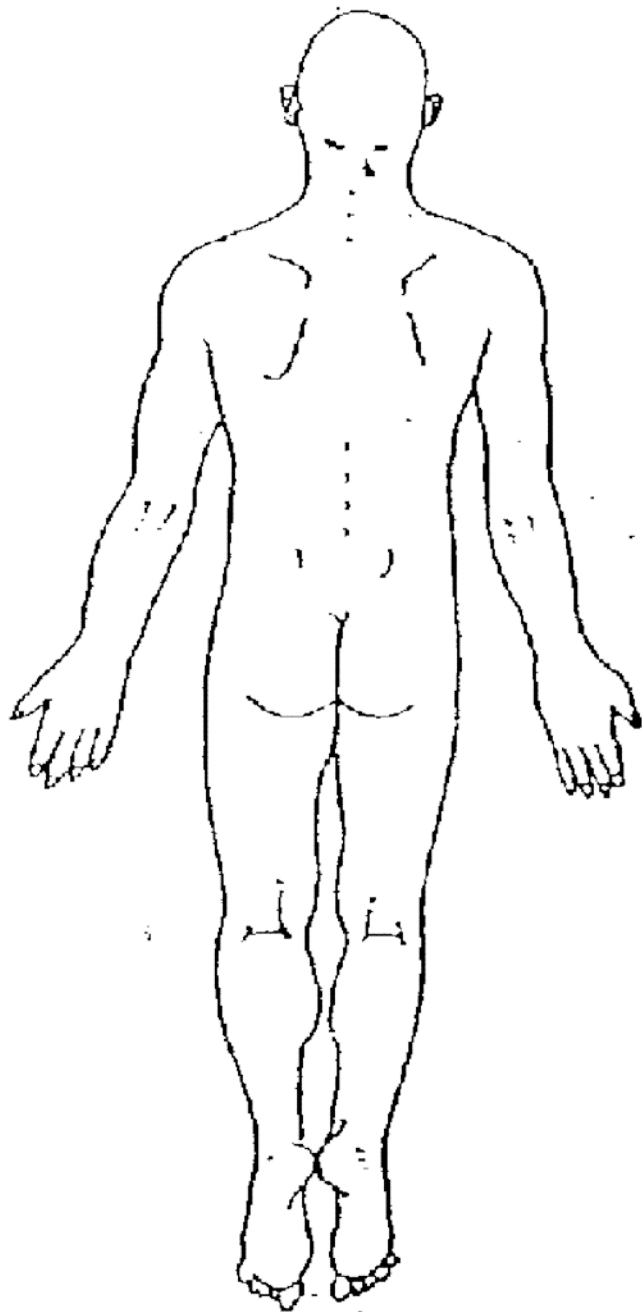
Referring Physician's Address _____

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

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain					Worst Possible Pain

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
<u>Surgery</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nerve Block</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>TENS/MENS</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Physical Therapy</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Occupational Therapy</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Biofeedback/Relaxation Therapy</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Professional Psychological Support</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Other:</u>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | |
|---|-------|
| <input type="checkbox"/> Heart Problems | _____ |
| <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Circulation problems | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Kidney/Bladder problems | _____ |
| <input type="checkbox"/> Liver Problems | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Blood disorders | _____ |
| <input type="checkbox"/> Lung problems/Asthma | _____ |
| <input type="checkbox"/> Intestinal problems/Ulcers | _____ |
| <input type="checkbox"/> Blackout/Falls | _____ |
| <input type="checkbox"/> 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.)

