PLEASE COMPLETE ALL SECTIONS

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PAIN QUESTIONAIRE

Name: _____ Age: _____ Gender: _____ Date: _____

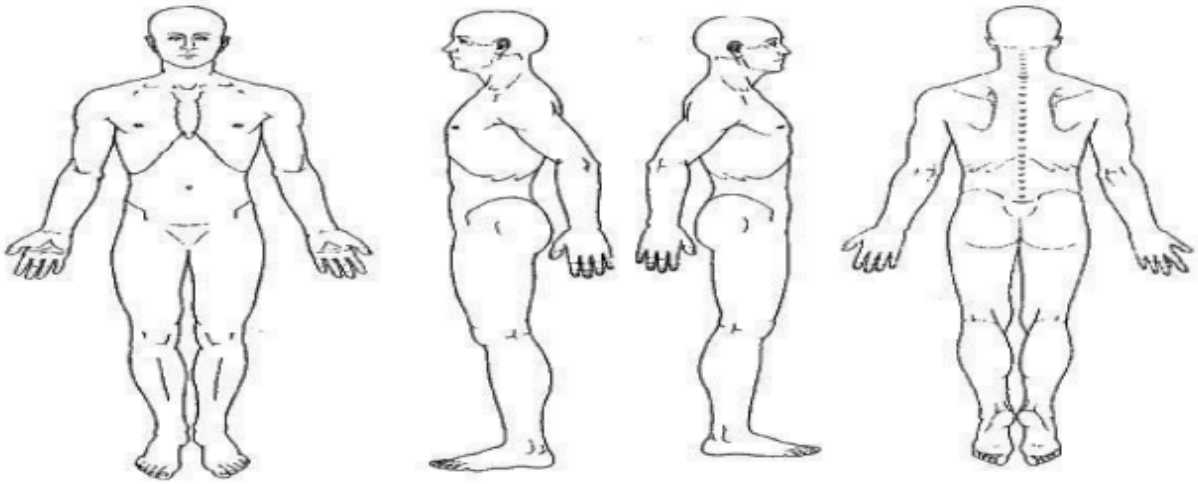
Where is your worst pain? _____

How did the pain start? _____

_____

_____

Please mark the diagram: P=Pain, B=Burning, T=Tingling, N=Numbness, W=Weakness



Pain Scale: (Circle the number that represents your current level of pain.)

NO PAIN **UNBEARABLE**

☐ ☐ ☐ ◯ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Circle the best response(s) for the following questions

When is your pain at the worst? MORNING ◯ AFTERNOON ◯ EVENING ◯

When is your pain at its best? MORNING ◯ AFTERNOON ◯ EVENING ◯

Is your pain? CONSTANT FREQUENT ◯ INTERMITTENT ◯ OCCASIONAL ◯

How would you describe your pain? Sharp ☐ Aching ☐ Burning ☐ throbbing ☐ Shooting ☐ Electric like ☐
Indescribable Other _____

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What worsens your pain? Standing ☐ Walking ☐ Sitting ☐ Activity ☐ Bending ☐ Twisting ☐ Lying down ☐
Other _____

What relieves your pain? Medication ☐ Sitting ☐ Lying down ☐ Standing ☐ Physical Therapy ☐

Chiropractic Manipulation Heat Ice Other _____

Does your pain affect any of the following? Concentration ☐ Work Duties ☐ Activities of Daily ☐
Living Physical Activity ☐ Appetite ☐ Sleep ☐ Other _____

Have you ever been to a pain management clinic in the past for your complaint? Yes ☐ No ☐

If yes, when and where and who did you see? _____

_____

Please identify which of the following pain medications have been tried on the past by checking the appropriate box. **(Do not check any drug never taken)**

	Helpful?			Helpful?			Helpful?	
NSAIDs	**Y**	**N**	**Muscle Relaxants**	**Y**	**N**	**Anticonvulsants**	**Y**	**N**
Motrin			Skelaxin			Neurontin		
Lodine			Norflex			Lamictal		
Naprosyn			Soma			Topomax		
Relafen			Robaxin			Depakote		
Indocin			Flexeril			Tegretal		
Celebrex			Zanaflex			Dilantin		
Mobic			Valium			Lyrica		
Opioid **(Narcotic)**			**Others**			**Antidepressant**		
Darvocet			Stadol			Elavil		
Percocet			Talwin			Pamelor		
Lortab/Vicodin			Fioricet			Doxepin		
Norco			Ultram (tramadol)			Tofranil		
Duragesic			Zostrix			Desyrel		
Dilaudid			Ketamine			Welbutrin		
Oxycontin			Lidoderm			Anafranil		
MS Contin			Imitrex			Luvox		
MS IR			Amerge			Zoloft		
Kadian			DHEA			Remeron		
Levorphanol			Guiafensin			Paxil		
Methadone			Dextromethorphan			Prozac		
Atiq			Steroids			Serzone		
Opana			Suboxone			Effexor		
Exalgo						Risperadol		
Butrans						Zyprexa		
Nucynta						Cymbalta		
						Savella		

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Please identify the previous pain treatments you have tried in the past, and indicate if they were helpful.

Helpful?

Treatment/Procedure	Y	N	Please Explain	Date of last visit/procedure
Physical/Occupational therapy				
Orthotic Device				
TENS unit				
Osteopathic Manipulation				
Epidural Injection				
Facet Block				
Nerve block				
Sacroiliac Joint Injection				
Trigger Point Injection				
Joint injection				
Acupuncture				
Chiropractor				
Stimulator/Pump				
Massage Therapy				

Past Medical History

Please indicate any current or past medical conditions you have been treated for

Cardiac	Y	N	**Pulmonary**	Y	N
Hypertension			Smoker		
Hypercholesterolemia			Asthma		
Coronary Artery Disease/MI			COPD/Emphysema		
Irregular Heart Beat			Sleep Apnea		
Atrial fibrillation/flutter			Lung Cancer		
Internal cardiac defibrillation/pacemaker			**Endocrine**		
Peripheral vascular disease			Diabetes		
Other:			Diabetic Peripheral Neuropathy		
Gastrointestional			Grave's Disease		
GERD			Hypothyroid		
Gastritis			Other:		
Gastric Ulcer			**Musculoskeletal**		
Irritable bowel disease			Osteoarthritis		
Hepatitis			Rheumatoid Arthritis		
Liver cirrhosis			Sjogren's disease		
Other:			Degenerative joint disease		
Renal			Fibromyalgia		
Renal insufficiency			Lyme's Disease		
Renal Failure			Other:		
Kidney Stones					
Other:					
Neurological			**Psychiatric**		
Stroke			Depression		

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TIA			Anxiety		
Migraines			Bipolar		
Seizure Disorder			Schizophrenia		
Multiple Sclerosis			Panic Disorder		
Alzheimer's Disease			Post-Traumatic Stress Disorder		
Dementia			History of alcohol/drug abuse		
Other:			Other:		
Hematological					
Anemia			Low platelets		
Bleeding disorder			Blood clots		
Leukemia			Lymphoma		
Other:			Other:		

Surgical History

Date	Surgery	Date	Surgery

Social History

Circle all that apply

Do you currently smoke tobacco? YES NO If Yes: How many packs per day? _____

How many years? _____ If ex-smoker: when did you quit? _____

Do you currently drink alcohol? YES NO If Yes: BEER LIQUOR WINE

Amount per day? _____ Amount per week? _____

Do you currently use any illicit drugs? YES NO f Yes: What do you use? _____

Currently working? YES NO FULL-TIME PART-TIME RETIRED
DISABLED Occupation/Former occupation? _____

Family History

Check all that apply

	Hypertension	Diabetes	Heart Disease	Cancer (what type?)	Lung Disease	Other
Mother						
Father						
Siblings						
Grandparents						
Aunts/Uncles						

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Current Medications

Medication	Dose/Frequency	Medication	Dose/Frequency

Are you currently taking any of the following anticoagulants (circle all that apply)?

Aspirin ☐ Coumadin ☐ Plavix ☐ Aggrenox ☐ Xarelto ☐ Pradaxa ☐ Eliquis ☐ Lovenox ☐

Allergies/Intolerances

Medication	Reaction

Imaging/Studies with dates and location

Type of study	Date	Location
MRI		
CT Scan		
X-ray		
EMG		
Other		

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Review of Systems

Have you recently had any of the following problems or symptoms (in the past 3-6 months)? (circle all that apply)

Constitutional
Chills
Fever
Weight loss
Decline in Health
weakness
Fatigue
Weight gain

Head
Dizziness
Headaches
Fainting
Pain
Head Injury
Sweats

Eyes
Blurry vision
Double Vision
Eyeglass Use
Pain with Light
Unusual sensations
Cataracts
Excessive tearing
Glaucoma
Recent Injury
Vision Loss
Discharge
Eye Pain
Infections
Redness

Nose
Discharge
Infections
Sinus Infections
Frequent Colds
Nasal Obstruction
Hay Fever
Nosebleeds

Mouth
Bleeding gums
Postnasal drip
Change in Dentition
Tongue Burning
Hoarseness
Voice Changes

Ears
Discharge
Hearing Impairment
Ringing in Ears
Dizziness
Infections
Hearing Aid
Pain

Throat/Neck
Frequent Sore Throats
Tonsils Enlarged
Lumps
Tenderness

Respiratory
Asthma
Bronchitis
Pleurisy
Short of Breath
Cough
Coughing Blood
Positive TB Test
Sputum
Wheezing
Pain
Recent X-ray
Tuberculosis

Cardiovascular
Chest Pain
Extremity(s)
Palpatations
Extremity(s) Discolored
Heart Tests (Not EKG)
Varicose Veins
Hair Loss on Legs
High Blood Pressure

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Heart Murmur
History of Heart Attack
Rheumatic Fever
Short of Breath-Sleeping
Ulcers on Legs

Leg Pain-Walking
Short of Breath-Exertion
Swelling of Legs

Recent Electrocardiogram
Short of Breath-Lying Flat
Thrombophlebitis

Gastrointestional
Abdominal Pain
Heartburn
Rectal Bleeding
Black Tarry Stools
Change in Stool Color
Excessive Hunger
Hemorrhoids
Laxative Use
Swallowing Problem

Constipation
Jaundice
Abdominal X-ray Tests
Change in Frequency of BM
Change in Stool Consistency
Excessive Thirst
Hepatitis
Nausea
Vomiting

Diarrhea
Liver Disease
Antacid Use
Change in Stool Calibur
Decreased Appetite
Gallbladder Disease
Infections
Rectal Pain
Vomiting Blood

Musculoskeletal
Arthritis
Back Problem
Muscle Cramps
Restricted Motion

Joint Pain
Deformities
Muscle Stiffness
Weakness

Gout
Joint Stiffness
Paralysis

Psychiatric
Depression
Disturbing Thoughts
Memory Loss
Psychiatric Disorders

Behavioral Change
Excessive Stress
Mood Changes

Disorientation
Hallucinations
Nervousness

Breasts
Discharge
Self-examination

Lumps
Tenderness

Pain

Skin
Eczema
Easy Bruisability
Hives
Nail Appearance Change
Skin Color Change

Itching
Hair Dye
Lumps
Nail Texture Change

Dryness
Hair Texture Change
Mole Increased Size
Rashes

Neurological
Loss of Consciousness
Dizziness
Headaches
Paralysis
Tingling

Blackouts
Fainting
Memory Loss
Speech Disorders
Tremors

Burning
Head Injury
Numbness
Strokes
Unsteady Gait

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Endocrine
Weakness
Cold Intolerance
Goiter
Neck Pain
Weight Gain
Excessive Urination
Heat Intolerance
Sweats
Weight Loss
Fatigue
Increased Thirst
Thyroid Trouble

Hematologic/Lymph
Anemia
Easy Bruisability
Swollen Glands
Bleeding Easily
Lumps
Transfusion Reaction
Blood Clots
Radiation Exposure

Allergic/Immunologic
Coughing
Itchy Eyes
Runny Nose
Watery Eyes
Coughing with Exercise
Itchy Nose
Sneezing
Wheezing
Hives
Recurrent Infections
Stuffy Nose
Wheezing with Exercise

Urinary
Awakening to Urinate
Burning
Flank Pain
Infections
Stones
Urine Odor
Bed-Wetting
Difficulty Starting Stream
Frequency
Pain on Urination
Urgency
Blood in Urine
Excessive Urination
Incontinence
Retention
Urine Discoloration

Male Genitalia
Discharge
Impotence
Prostate Problems
Venereal Disease
Fertility Problems
Lesions
Scrotal Masses
Hernias
Pain
Sexual Problems

Female Genitalia
Birth Control
Change in Periods-Flow
Difficult Pregnancy
Hernias
Menopause
Postmenopausal Bleeding
Sexual Problems
Bleeding Between Periods
Change in Periods-Interval
Discharge
Itching
Menstrual Pain
Recent Pap Smear
Venereal Disease
Change in Periods-Duration
DES Exposure
Fertility Problems
Lesions
Pain on Intercourse
Current or Recent Pregnancy