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Pain Questionnaire

Date _____

First name _____ Last name _____ Middle initial _____

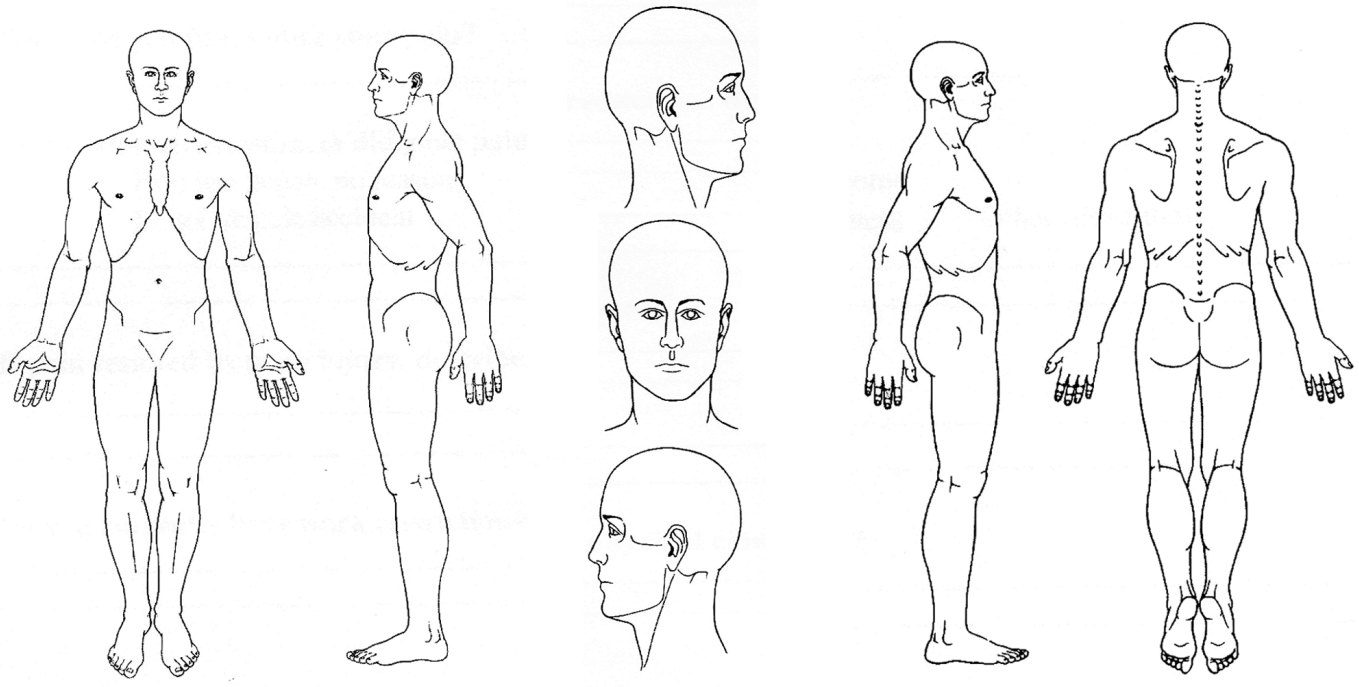
Date of birth _____

Sex Male____ Female____

Height _____ Weight _____

Referring physician _____ Primary care physician _____

Where is your pain located? (Please shade the painful areas on the diagram below.)



How would you describe your pain?

_____ Burning
_____ Sharp
_____ Aching
_____ Throbbing
_____ Shooting
_____ Numbness
_____ Other (describe)

_____

_____

_____

Which statement best describes your pain?

_____ Always present, always the same intensity
_____ Always present, intensity varies
_____ Pain comes and goes

Does your pain interrupt your sleep?

_____ Not at all
_____ 1 to 2 times per night
_____ 2 to 3 times per night
_____ More than 3 times per night

What makes your pain feel worse?

_____ Coughing, sneezing
_____ Sitting
_____ Standing
_____ Lying down
_____ Walking
_____ Physical activity
_____ Other (describe)

What makes your pain feel better?

_____ Relaxation
_____ Sitting
_____ Standing
_____ Lying down
_____ Nothing makes me feel better
_____ Other (describe)
_____ Walking
_____ Heat
_____ Medicines

Circle a number from 0 to 10 to indicate how strong your pain is at its worst.

0 1 2 3 4 5 6 7 8 9 10

Circle a number from 0 to 10 to indicate how strong your pain is on the average.

0 1 2 3 4 5 6 7 8 9 10

When did you first notice your pain?

Under what circumstances did your pain begin?

_____ No reason, it just began
_____ Accident at work
_____ Accident at home
_____ Motor vehicle accident
_____ Following surgery
_____ Following illness
_____ Other (describe)

If your pain resulted from an injury, describe how it happened.

Describe any work restrictions or reductions due to your physical condition.

Has your pain limited any of the following activities?

_____ Walking
_____ Climbing stairs
_____ Getting in and out of bed
_____ Getting up and down from a chair
_____ Balance
_____ Feeding/grooming/bathing

Since your pain began, has it:

_____ Increased
_____ Decreased
_____ Stayed the same

Have you been hospitalized for your pain?

_____ No
_____ Yes (if yes, where?)

_____

_____

_____

Have you had any of the following treatments for your pain?

Epidural injection	_____ yes	_____ no	If yes, did it help? _____
Trigger point injections	_____ yes	_____ no	If yes, did it help? _____
Nerve blocks	_____ yes	_____ no	If yes, did it help? _____
Physical therapy	_____ yes	_____ no	If yes, did it help? _____
Chiropractic treatment	_____ yes	_____ no	If yes, did it help? _____
Acupuncture	_____ yes	_____ no	If yes, did it help? _____
TENS	_____ yes	_____ no	If yes, did it help? _____
Pain medications	_____ yes	_____ no	If yes, did it help?

List pain medications that your have tried before: _____

_____

_____

Are you allergic to any medications?

_____ yes _____ no If yes, what are the names of the medications?: _____

_____

_____

Do you smoke? _____ yes _____ no If yes, how many packs per day? _____

Do you drink alcohol? _____ yes _____ no If yes, approximately how many drinks per week? _____

Do you do any street drugs? _____ yes _____ no If yes, what kind of drugs? _____

Does anyone in your family have chronic pain or disability?

_____ yes _____ no If yes, please explain: _____

_____

_____

Do you have any other health problems?

_____ High blood pressure
_____ Diabetes
_____ Heart disease
_____ Stroke
_____ Seizures
_____ Kidney disease
_____ Liver disease
_____ Lung disease
_____ Thyroid disease
_____ Arthritis
_____ Peptic ulcer/reflux
_____ Cancer
_____ Frequent headaches
_____ Psychiatric diseases

Have you had previous surgeries?

_____ none

_____ yes (please list)

_____

_____

_____

_____

Please list all medications you are taking with the dosage and frequency.
Include over-the-counter medications, like Tylenol, Advil, herbal, etc.

Medication	Dosage	Frequency

This questionnaire was completed by:

Patient _____ Date _____

Parent/guardian _____ Date _____

Other _____ Date _____

Do you have any of the following symptoms?

	Yes	No	If yes, where:
Numbness			
Weakness			
Muscle spasms			
Skin discoloration			
Coldness			
Increase in sweating			
	Yes	**No**	**If yes, describe:**
Bowel problems			
Bladder problems			
Recent weight gain			
Decreased appetite			
Fever			
Sore throat			
Hoarseness of voice			
Difficulty swallowing			
Chest pain			
Swelling of legs			
Irregular heart beat			
Difficulty lying flat on your back			
Wheezing			
Shortness of breath at rest or exertion			
Coughing			
Diarrhea			
Nausea and vomiting			
Joint swelling			
Seizures			
Difficulty sleeping			
Mood swings			
Depression			
Skin rash			
(Women) Are you pregnant or trying to get pregnant?			
Excessive bleeding Do you bleed more than expected?			
Has a dentist told you that you bleed more than usual?			
Have you had trouble with bleeding after surgery?			