AINSWORTH INSTITUTE OF PAIN MANAGEMENT

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INITIAL VISIT
PAIN QUESTIONNAIRE

Name: _____ Date: _____/_____/_____
Last First M.I.

DESCRIBE YOUR PAIN

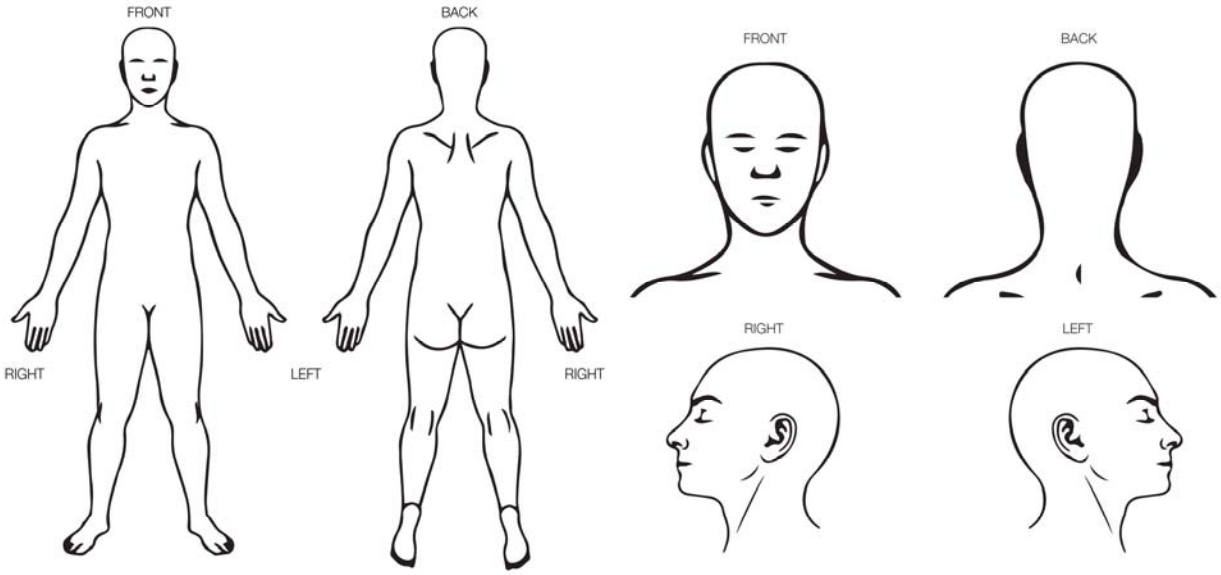
(1) What is the main problem or area of pain that your are seeking treatment for?

_____

_____

_____

Please mark the area(s) where your pain is located:



ONSET & DURATION

(2) Please describe the onset of the your pain. How did it begin?

_____

_____

_____

(3) When did id begin? (Approximate date): _____

*Patient Name*_____

QUALITY AND INTENSITY

	None	Mild	Moderate	Severe
Throbbing	0)_____	1)_____	2)_____	3)_____
Shooting	0)_____	1)_____	2)_____	3)_____
Stabbing	0)_____	1)_____	2)_____	3)_____
Sharp	0)_____	1)_____	2)_____	3)_____
Cramping	0)_____	1)_____	2)_____	3)_____
Gnawing	0)_____	1)_____	2)_____	3)_____
Hot-Burning	0)_____	1)_____	2)_____	3)_____
Aching	0)_____	1)_____	2)_____	3)_____
Heavy	0)_____	1)_____	2)_____	3)_____
Tender	0)_____	1)_____	2)_____	3)_____
Splitting	0)_____	1)_____	2)_____	3)_____
Tiring-Exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing-Cruel	0)_____	1)_____	2)_____	3)_____

Rate the intensity of your pain on the two scales below. Make a mark on the line to indicate where your pain falls between *NO PAIN* and *WORST POSSIBLE PAIN* and then circle the appropriate number on the second scale.

NO PAIN

WORST POSSIBLE PAIN

Circle one of the following words that best describes your current pain:

0 No Pain
1 Mild
2 Discomforting
3 Distressing
4 Excruciating

*Patient Name*_____

Initial Visit Pain Questionnaire cont.

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(4) Do you feel numbness? Y N

(5) Do you feel pins & needles? Y N

(6) Do you feel electricity? Y N

TIMING

(7) How often is your pain present (please check one)?

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

(8) Circle your current pain level ("0" is no pain and "10" is the worst pain you could ever imagine):

0 1 2 3 4 5 6 7 8 9 10

(9) Circle your average pain over the last 7 days:

0 1 2 3 4 5 6 7 8

9

10

(10) Circle your best pain score over the last 7 days:

0 1

2

3

4

5

6

7 8

9

10

(11) Circle your worst pain score over the last 7 days:

0 1

2

3

4

5

6

7 8

9

10

RELIEVING AND AGGRAVATING FACTORS

Of the activities listed below, please check the box indicating whether it makes your pain better, worse or the same:

	Decrease (12)	Increase (13)	No Effect (14)
Lying Down			
Standing			
Sitting			
Walking			
Going up hill/stairs			
Going down hill/stairs			
Leaning forward			
Leaning backward			

*Patient Name*_____

Initial Visit Pain Questionnaire cont.

	Decrease (12)	Increase (13)	No Effect (14)
Hunching forward on cart/walker			

Exercise
Medication
Coughing/Sneezing
Urination
Bowel Movements
Eating/Chewing
Swallowing

PAIN TREATMENT

What has been done so far for you pain and how well has it worked?

Please provide the date for all of the treatments you have tried prior to today and then check the appropriate box for how well it worked:

	Date (15)	Excellent Relief (16)	Moderate Relief (17)	No Relief (18)
Physical Therapy				
Chiropractic				
Trigger Point Inj				
Epidural/Nerve Block				
Massage Therapy				
TENS Therapy				
Acupuncture				
Surgery				
Biofeedback				
Psychotherapy				
Other:_____				

FUNCTIONAL LIMITATIONS

(19) How man blocks can you walk before having to stop from pain? _____

(20) How long can can you stand before you have to sit down?

_____ hours _____ minutes

(21) How long can you sit before having to get up and/or change positions?

_____ hours _____ minutes

*Patient Name*_____

Initial Visit Pain Questionnaire cont.

PREVIOUS DIAGNOSTIC STUDIES

Please indicate the approximate date of the relevant tests listed below, if any, and the results:

(15) MRI: _____

(16) CT: _____

(17) Xray: _____

(18) EMG: _____