PAIN QUESTIONNAIRE

Office use only:
(UA Done__yes__No)

Last Name_____ First Name_____Middle_____

Address_____ Apt. #_____

City_____State _____Zip Code_____

Date of Birth_____Age_____SS #_____

Phone #_____ Weight_____ Height_____

1. Who referred you to us? ☐ Self ☐ Other _____
2. Are you currently pregnant? ☐ Yes ☐ No 3. When was your last menstrual cycle?_____

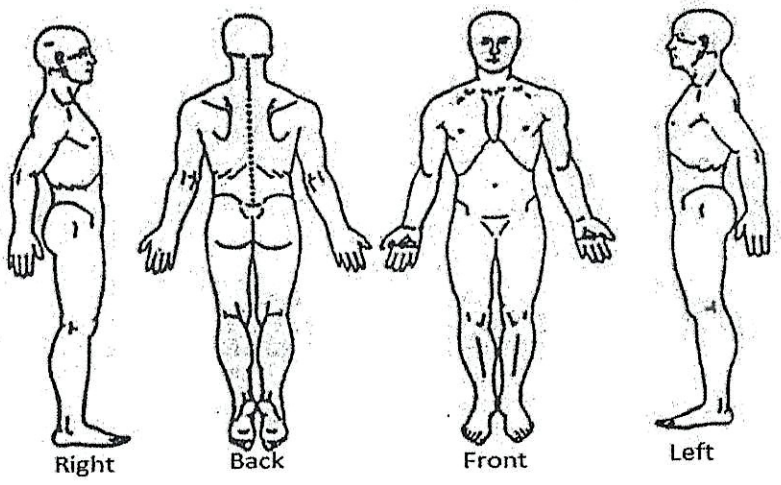
4. **Circle** what event(s) led to your present pain: Cancer Accident- Date_____
   Fall-*Date*_____ Pain following operation No known cause
   Other problem _____
   Describe the event: _____
   _____
   _____

5. **Circle** the word(s) that best describe your pain:

Throbbing	Shooting	Aching	Dull	Sore	Numbness	Tingling	Stabbing
Cutting	Heavy	Cramping	Tender	Burning	Pressure	Stinging	Itching

6. How long have you had this pain?_____
   Has your pain worsened in the last 6 months? ☐Yes ☐No

7. Label the areas that hurt with an "X" on the diagram below.



8. **Circle** what your pain level is **now**: 0 = no pain 1 2 3 4 5 6 7 8 9 10 = worse pain ever
   Circle what your pain level is at its **worst**: 0 1 2 3 4 5 6 7 8 9 10
   Circle what your pain level is at its **best**: 0 1 2 3 4 5 6 7 8 9 10
9. **Circle** how often your pain occurs: Continuously (non-stop) Several times a day Once or twice a day
   Once or twice a month Less than once a month Rarely
10. When is your pain worse the most? **Circle only one answer:** Morning Day Evening Night
11. When is your pain better the most? **Circle only one answer:** Morning Day Evening Night

12. Circle what position(s) INCREASE your pain: Sitting Standing Lying Bending
    Walking Turning Other_____
13. Circle what position(s) DECREASE your pain: Sitting Standing Lying Bending
    Walking Turning Other_____
14. Circle any of these activities that you CANNOT DO OR HAVE DIFFICULTY DOING because of your pain: Walk Work Drive Swim Dance Grocery shop Climb stairs
    Dress/undress Family activities Play/recreation Sex Jog Sleep
15. I have trouble falling asleep? □ Yes □No I wake up _____# times due to pain.
16. Circle any that you use: Cane Walker Wheelchair Brace Crutches Orthopedic shoes
17. Circle your current level of stress: 0 = no stress 1 2 3 4 5 6 7 8 9 10 = very stressed
18. Circle the word(s) that describe(s) how your pain makes you feel: Angry Tense Depressed
    Irritable Scared Sad Nervous Like you want to cry Restless Other_____

    Do you feel like you have little control over much of what happens to you? □ Yes □ No
    Do you feel like doing many of the things you used to do? □ Yes □ No
    Do you often feel guilty burdening others with your problems? □ Yes □ No
    Do you have thoughts that you would rather not be alive? □ Yes □ No

19. Does your pain affect: Bowel action? □ Yes □ No Bladder action? □ Yes □ No
20. Have you ever been to a hospital emergency room because of THIS problem? □ Yes □ No
    What treatment did you receive?_____
21. Have you ever been admitted to a hospital for THIS problem? □ Yes □ No
22. Are you currently working? □ Yes □ No If yes, indicate □ full duty or □ light duty
    Employer_____ Job_____
23. Do you have legal action pending related to your pain or health problem? □ Yes □ No
24. Only check what treatments you have tried for your pain? (Leave blank if NOT tried.)

___Tranquilizers	□ Yes	□ No	___Pain relievers	□ Yes	□ No
___Surgery	□ Yes	□ No	___Traction	□ Yes	□ No
___Nerve blocks	□ Yes	□ No	___Muscle injections	□ Yes	□ No
___Braces or cast	□ Yes	□ No	___Acupuncture	□ Yes	□ No
___Chiropractic	□ Yes	□ No	___Massage	□ Yes	□ No
___Physical therapy	□ Yes	□ No	___Psychotherapy	□ Yes	□ No
___TENS	□ Yes	□ No	___Biofeedback	□ Yes	□ No
___Relaxation training	□ Yes	□ No	___Hypnosis	□ Yes	□ No
___Home exercise	□ Yes	□ No	___Homeopathy	□ Yes	□ No

Other_____

25. **Check** which **DIAGNOSTIC TESTS** you have had for your **PAIN:**
    ___MRI___ Bone scan ___EKG ___CAT scan ___X-ray
    ___ EMG/Nerve conduction study ___ Blood work ___ Myelogram

26. Please list all **ALLERGIES:** _____

27. Please list all **MEDICATIONS** you are **NOW TAKING:** (list all prescriptions or over-the-counter)

Drug	**Strength**	**# of pills per day**	**Effect on pain**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

28. What medications **not** listed above have you tried in **THE PAST FOR YOU PAIN?**

Drug	**Strength**	**# of pills per day**	**Effect on pain**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

29. **Circle** any **blood thinners** you currently take: Coumadin (warfarin, jantoven) Plavix (clopidogrel) Aspirin
Triclid Trental(pentoxifylline) Aggrenox Excedrin(with aspirin) BC Powders Vitamin E
Brilinta Eliquis Pradaxa Xarelto

30. **FAMILY HEALTH HISTORY: Check** if anyone in your **family** has a history of any of the following health Conditions (**DO NOT** include yourself.) **LIST** their **RELATIONSHIP** to you:

☐ Cancer/Who? _____TYPE_____ ☐ Diabetes/Who? _____☐ CVA/Stroke, Who? _____ ☐ COPD/Who? _____
☐ Hypertension/Who? _____ ☐ Arthritis/Who? _____ ☐ Migraines/Who? _____☐ Heart attack/disease/Who? ____
☐ Other _____

31. **YOUR HEALTH HISTORY: Check** if you have a history of any of these health conditions:

Heart trouble? ☐ Yes ☐ No, I do not have any problems with my heart.
___ Heart disease ___ Irregular heartbeat ___Congestive heart failure
___ Angina ___ High blood pressure ___ Pacemaker
___ Heart attack (Date_____)

Lung problems? ☐ Yes ☐ No, I do not have any problems with my lungs.
___ Asthma ___ Emphysema ___Sinus infection
___ Bronchitis ___ Pneumonia (Date_____)
___ Shortness of breath ___ Pulmonary embolism (blood clot on lungs)

Neurological problems? ☐ Yes ☐ No, I do not have any neurological problems.
___ Headaches ___ Head injury ___Stroke ___ TIA's
___ Visual disturbances ___ Memory loss ___ Multiple Sclerosis
___ Cataracts ___ Seizures ___ Dizziness

Musculoskeletal problems? ☐ Yes ☐ No, I do not have any musculoskeletal problems.
___ Muscle spasms ___ Arthritis ___Fibromyalgia ___ Phlebitis
Fractures: _____

HEALTH HISTORY (continued): (**check** if you have a history of any of these health conditions)

Digestive problems? □ Yes □ No, I do not have any digestive problems.

___ Ulcers	___Hepatitis	___Liver Disease
___ Hiatal hernia	___ Colitis	___ Crohn's Disease
___ Diverticulosis	___ Pancreatitis	___ Gall bladder

Endocrine problems? □ Yes □ No, I do not have any endocrine problems.

___ Diabetes	___Hypothyroid	___Hyperthyroid
___ Parathyroid glands	___ Adrenal glands	___ Kidney problem

Have you ever had cancer? □ Yes □ No If yes, where?

___ Brain	___Breast	___Lung	___Colon
___ Prostate	___Rectal	___Lymphoma	___Leukemia
___ Myeloma	___ Other_____		

Cancer Treatment? □ Yes □ No, I have never had any of these treatments.

___ Surgery	___Chemotherapy	___Radiation
___Hormones	___ Other _____	

32. Have you any **SURGERIES? OPERATIONS?** □ Yes □ No
If yes, what kind and when: _____
_____

33. **SOCIAL HISTORY:** Do you **smoke?** □ Yes, # of packs a day _____, years _____ □ No
Former smoker? □ Yes, # of packs a day _____ , years_____, years quit _____
Alcohol? □ Yes, # drinks per day _____ □ No
Coffee? □ Yes, # cups per day _____ □ No
Recreational / illegal drugs? □ Yes □ No

Check one: □ Married □ Divorced □ Widow □ Single □ Separated
Retired? □ Yes □ No **Disabled?** □ Yes □ No
Who lives with you at home? _____

30. Have you ever been diagnosed with any of the following? (**check** if you have been diagnosed)

___ Depression	___Schizophrenia	___Paranoid
___ Psychosis	___Panic attacks	___Bipolar (Manic/Depressive)
___ Anxiety	___Attention Deficit Disorder	___Suicide behavior, if yes, when____