We are interested in understanding more about your pain. Please help us by filling out this questionnaire. Please ***bring the completed questionnaire with you for your first appointment. Your appointment may be delayed if you do not arrive with the completed questionnaire. If you need assistance completing the form, contact the pain management center.***

Name_____ Date of Birth: _____

Primary Care Physician: ___ Referring Physician (if different):

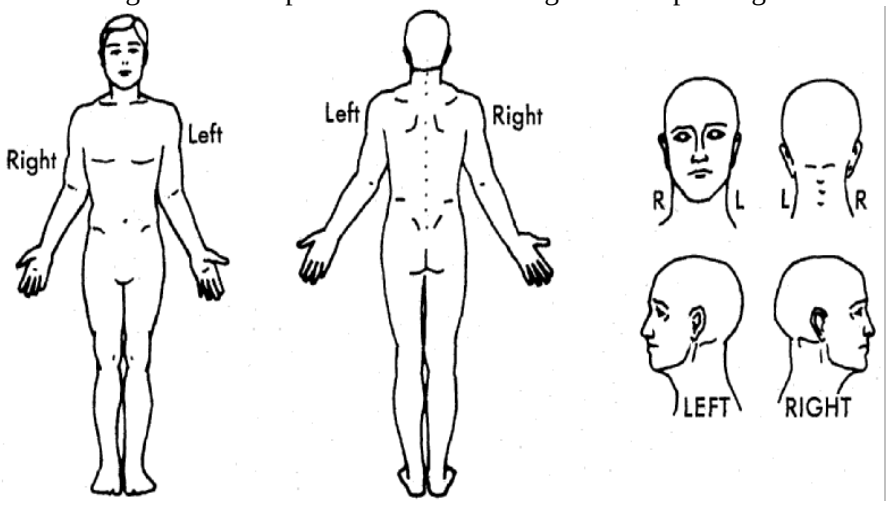
Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____

Have you ever been to a pain specialist before? ☐ YES ☐ NO If yes, list name of Physician/practice: _____ Phone:_____

When did your pain begin? _____

Where is your pain?

Please use the diagram below to indicate where your most painful areas are located. Shade in these areas darkly and shade in your less painful areas lightly. If the pain radiates of travels from one place to another, please include it on the diagram. Please print and mark the diagram after printing.



Using the scale below, please rate the level of your pain on a scale of 0 (no pain) to 10 (worst pain imaginable) for the following:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst pain imaginable)

PRESENT level of pain:0 **WORST** level of pain you've had:0 **LEAST** level of pain you've had:0
Using the same scale (0-10), what level of pain is acceptable to you or tolerable for you? 0

How would you describe your pain? (Circle.)
Aching Throbbing Sharp Dull Shooting Burning other_____

Is your pain the result of an:	NO	YES	If yes, explain and give dates.
Illness	☐	☐	_____
Accident/injury	☐	☐	_____

Are you presently involved in litigation or a lawsuit resulting from this accident? ☐ NO ☐ YES
Are you being treated under Worker's compensation? ☐ NO ☐ YES
If yes, what is the name of your attorney? _____

Please indicate if the following increases, decreases your pain.

What increases the pain?	☐ Cold	☐ Heat	☐ Weather changes	☐ Physical activity
	☐ Massage	☐ Pressure	☐ Movement	☐ Lying down
	☐ Sitting	☐ Standing	☐ Urination	☐ Bowel movement
	☐ Fatigue	☐ Sneezing, coughing		
What decreases the pain?	☐ Cold	☐ Heat	☐ Weather changes	☐ Physical activity
	☐ Massage	☐ Pressure	☐ Movement	☐ Lying down
	☐ Sitting	☐ Standing	☐ Urination	☐ Bowel movement
	☐ Fatigue	☐ Sneezing, coughing	☐ Resting	☐ Pain Medication

Please check any of the following treatments you have had for the pain problem. Includes the dates and how well they relieved your pain.

TREATMENT	PAIN RELIEF YES	PAIN RELIEF NO	DATE DONE
☐ NERVE BLOCKS	☐	☐	_____
☐ EPIDURAL STEROID	☐	☐	_____
☐ SPINAL CORD STIMULATOR	☐	☐	_____
☐ TENS UNIT	☐	☐	_____
☐ PHYSICAL THERAPY	☐	☐	_____
☐ TRACTION	☐	☐	_____
☐ ACUPUNCTURE	☐	☐	_____
☐ CHIROPRACTOR	☐	☐	_____
☐ PSYCHIATRIST	☐	☐	_____
☐ HYPNOSIS	☐	☐	_____
☐ BIOFEEDBACK	☐	☐	_____

What medications have you used <u>in the past</u> to treat your pain, including non-prescriptions medications?
☐ Over The Counter ☐ NSAIDs (anti-inflammatory) ☐ Pain Killers (opioids)

Using the scale below rate your daily functioning zero being non functional and 10 being fully functional.

Non-functional										Fully functional		
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**general activity**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**mood**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**walking ability**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**normal work routine**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**sleep**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**appetite**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**relationships with others**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**n/a**	**enjoyment of life**

WHAT ARE YOUR FUNCTIONAL GOALS? (ex: return to work, improved mood, increased Socialization with others, etc.)_____
_____

Do you smoke? ☐ NO ☐ YES If yes, how much and for how long?
_____

How much coffee or caffeinated beverages (tea, cola, etc.) do you drink daily?
_____

How much beer or alcoholic beverages do you drink daily? If so, what kind?
_____

Do you use recreational drugs? ☐ NO ☐ YES If yes, what drugs? How much? How?
_____

Have you ever (now or in the past) had problem with drug or alcohol abuse? ☐ NO ☐ YES

What is your usual occupation?_____ Are you presently working ? ☐ YES ☐ NO

Are you retired? ☐ NO ☐ YES Are you on disability? ☐ NO ☐ YES

What is the highest level of education you have achieved?_____
Please list the name, relationships and ages of the people who live with you. _____
_____

Please list you ALLERGIES and the reaction that you have, if known._____
_____

Please list all surgeries you have had, approximate dates, and surgeon's name. (use comments Section on the last page if you need more room.)

Surgery/Date/Surgeon

_____ _____
_____ _____
_____ _____
_____ _____

Please list any serious illness or hospitalizations you have had in the past.

_____ _____
_____ _____

Please check the appropriate box if you have had or presently have any of the following.

☐ AIDS	☐ Diabetes	☐ High Blood Pressure
☐ Asthma	☐ Depression	☐ Limb Circulation
☐ Cancer	☐ Epilepsy/Seizures	☐ Kidney Problems
☐ CVA (Stroke)	☐ Hepatitis	☐ Shingles
☐ Chronic Lung Disease	☐ Heart Disease	☐ Tuberculosis

Please indicate which diagnostic procedures (tests) you have had to evaluate your pain and the approximate date and location where the test was performed.

TESTS	LOCATION	DATE
☐ X-RAY	_____	_____
☐ EMG/NCV	_____	_____
☐ CT SCAN	_____	_____
☐ MYELOGRAM	_____	_____
☐ DISCOGRAM	_____	_____
☐ MRI SCAN	_____	_____

Do you have any other medical problems not already mentioned?_____

Please list those illnesses which run in your family. (eg. cancer, heart disease, kidney disease, lung disease)

Illness Family Relation (eg. mother)

_____ _____
_____ _____
_____ _____
_____ _____

Have you, or are you currently experiencing problems with any of the following?

YES	NO		comments
		CONSTITUTIONAL	
☐	☐	fever	_____
☐	☐	weight loss	_____
☐	☐	night sweats	_____
		HEAD/NECK/EYES	
☐	☐	blurred vision	_____
☐	☐	double vision	_____
☐	☐	frequent headache	_____
☐	☐	loss of vision	_____
☐	☐	neck pain	_____
☐	☐	pain in eyes	_____
☐	☐	neck lumps	_____
		EARS	
☐	☐	discharge from ears	_____
☐	☐	dizziness	_____
☐	☐	earaches	_____
		NOSE/THROAT	
☐	☐	frequent head colds	_____
☐	☐	frequent nose bleeds	_____
☐	☐	hoarseness	_____
☐	☐	problems with teeth	_____
☐	☐	sinus problems	_____
☐	☐	smell difficulty	_____
☐	☐	sore throat	_____
☐	☐	swallowing difficulty	_____
☐	☐	taste difficulty	_____
		RESPIRATORY	
☐	☐	coughing blood	_____
☐	☐	wheezing	_____
☐	☐	asthma	_____

YES	NO		comments
		MUSCULOSKELETAL	
☐	☐	arthritis	_____
☐	☐	swollen joints	_____
☐	☐	muscular pain	_____
☐	☐	chronic back pain	_____
☐	☐	shoulder pain	_____
☐	☐	morning stiffness	_____
		NEUROLOGICAL	
☐	☐	loss of strength	_____
☐	☐	fainting spells	_____
☐	☐	seizures	_____
☐	☐	tremors	_____
☐	☐	poor coordination	_____
		PSYCHIATRIC	
☐	☐	anxiety	_____
☐	☐	depression	_____
☐	☐	mood swings	_____
☐	☐	nervousness	_____
☐	☐	sleeping difficulty	_____
		ENDOCRINE	
☐	☐	excessive thirst	_____
☐	☐	excessive urination	_____
☐	☐	heat or cold intolerance	_____
☐	☐	thyroid problem	_____
		HEMATOLOGIC	
☐	☐	anemia	_____
☐	☐	easy bruising	_____
☐	☐	blood transfusions	_____

Continued on page 6…

YES	NO		comments
		CARDIOVASCULAR	
☐	☐	chest pain	_____
☐	☐	high blood pressure	_____
☐	☐	feet swelling	_____
☐	☐	ankle swelling	_____
☐	☐	poor circulation	_____
☐	☐	blood clots	_____
☐	☐	irregular heart beat	_____
☐	☐	thumping in the chest	_____
		GASTROINSTENTINAL	
☐	☐	indigestion	_____
☐	☐	stomach ulcer	_____
☐	☐	nausea/vomiting	_____
☐	☐	frequent constipation	_____
☐	☐	frequent diarrhea	_____
☐	☐	abdominal pain	_____
☐	☐	hemorrhoids/piles	_____
☐	☐	painful bowel movement	_____
☐	☐	chronic bloating	_____
☐	☐	vomiting of blood	_____
☐	☐	blood in stool	_____
☐	☐	jaundice	_____
☐	☐	heart burn	_____

YES	NO		comments
		SKIN	
☐	☐	rashes	_____
☐	☐	boils	_____
☐	☐	itching	_____
☐	☐	hives	_____
		URINARY	
☐	☐	blood in urine	_____
☐	☐	difficulty in urination	_____
☐	☐	inability to control urine	_____
☐	☐	kidney stones	_____
		MEN ONLY	
☐	☐	prostate trouble	_____
		WOMEN ONLY	
☐	☐	irregular periods	_____
☐	☐	severe menstrual cramps	_____
☐	☐	vaginal discharge	_____

COMMENTS: Please add any comments which you feel would help us in treating your pain.

_____

_____

_____

_____

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM.

SIGNATURE OF PATIENT:_____ DATE:_____