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        _____ Numbness
_____ Sharp          _____ Other (describe)
_____ Aching
_____ Throbbing
_____ Shooting
When did you first notice your pain?

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

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.


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

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


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

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

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0 1 2 3 4 5 6 7 8 9 10
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 you 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.

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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This questionnaire was completed by:

Patient _________________________________________________________________ Date _______________________

Parent/guardian _________________________________________________________ Date _______________________

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