

**Pain Questionnaire**

Date: \_\_\_\_\_

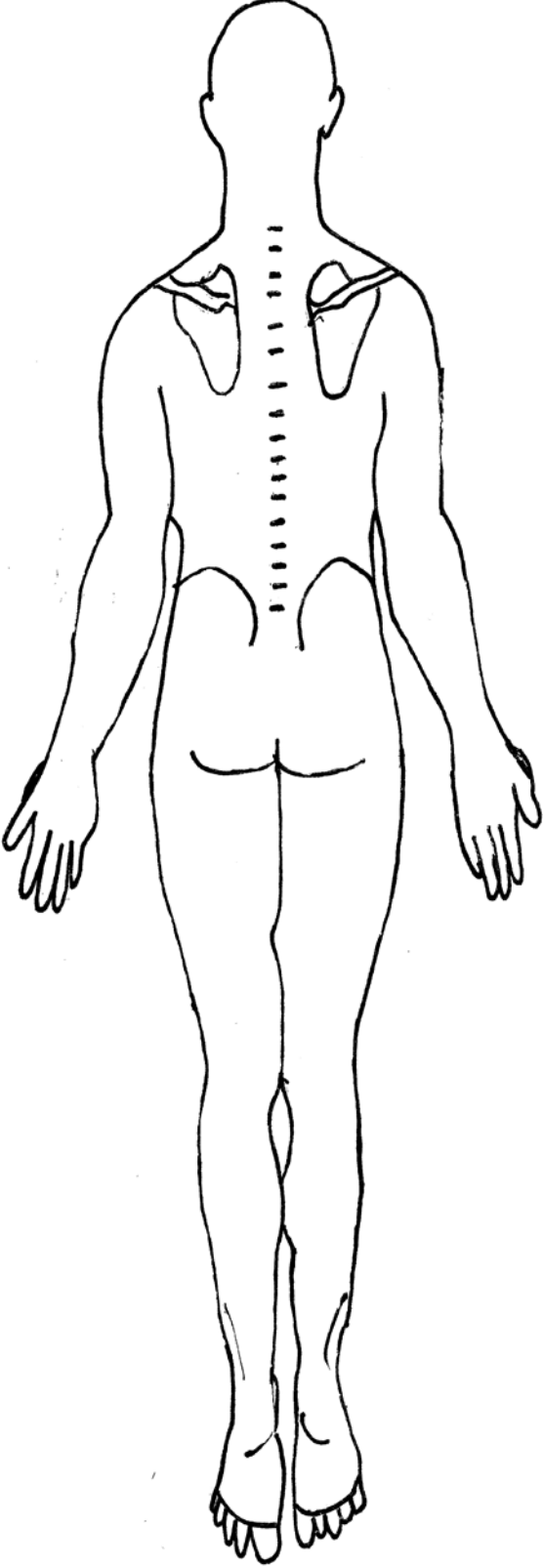
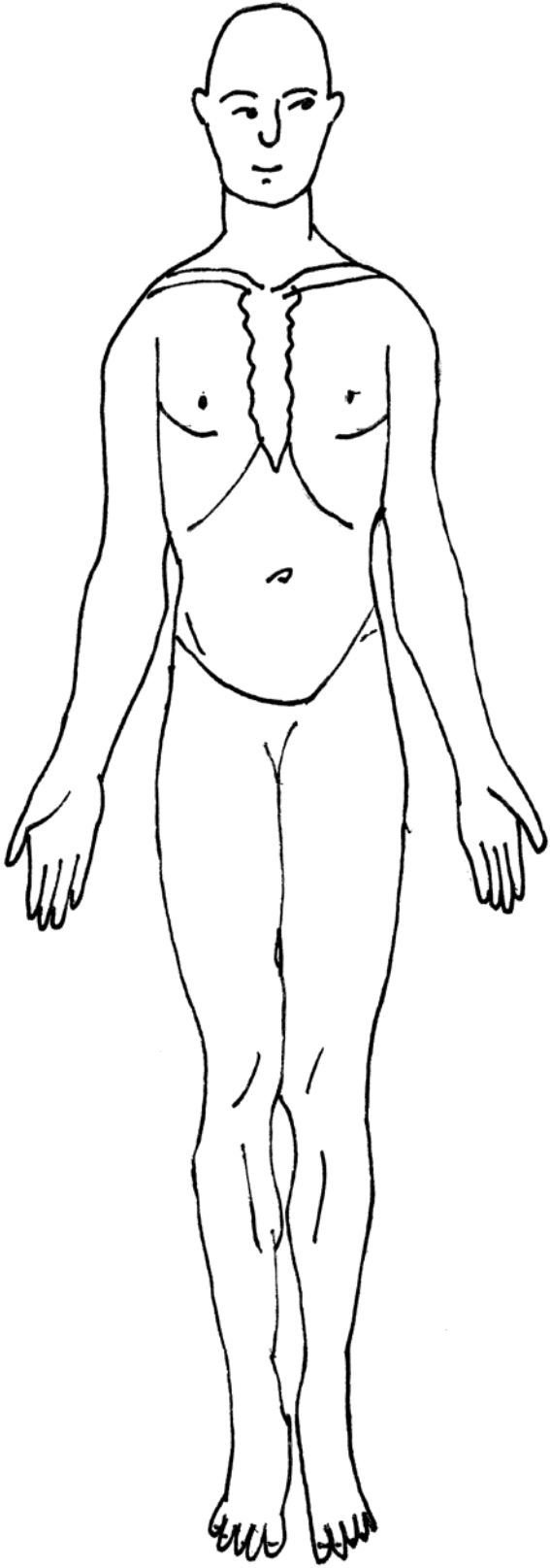
Name: \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: Home (\_\_\_\_\_) - \_\_\_\_\_

Work (\_\_\_\_\_) - \_\_\_\_\_



## PAIN HISTORY

Please consider each area of pain separately in answering the following questions.

1. List your painful areas individually with “A” the worst or most distressing area, “B” The second worst area, then, “C” [Ex: A: right arm, B: Left hand, C: Abdomen].

A: \_\_\_\_\_

B: \_\_\_\_\_

C: \_\_\_\_\_

2. When did you first notice each area of pain beginning (Month/ Day/ Year)?

A: \_\_\_\_\_

B: \_\_\_\_\_

C: \_\_\_\_\_

3. What do you believe caused each area of pain?

Pain A	Pain B	Pain C	Cause
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injury or accident at home
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injury or accident at work
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Result of illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Result of surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cause unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____





15. Have you been troubled by any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Trouble making decisions | <input type="checkbox"/> Difficulty focusing      |
| <input type="checkbox"/> Poor concentration       | <input type="checkbox"/> Unable to complete tasks |
| <input type="checkbox"/> Forgetfulness            | <input type="checkbox"/> None of these            |

16. What important events have happened to you in the last year?

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17. If you were without pain, what else would you do that you cannot do now?

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18. What would you do or give up to get rid of your pain condition?

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19. What do you expect to accomplish here at The Pain Center?

Pain Relief:

0 1 2 3 4 5 6 7 8 9 10  
(Complete Relief) (No Relief)

Function:

0 1 2 3 4 5 6 7 8 9 10  
(Complete Improvement) (No change)

Mood/Relationships:

0 1 2 3 4 5 6 7 8 9 10  
(Complete Improvement) (No change)

Work:

0 1 2 3 4 5 6 7 8 9 10  
(Returned to Pre-injury level) (Remain at present level)

20. If total relief cannot be achieved, what improvement would you want most?

Please check one item in each column:

Things you would Like	1 <sup>st</sup> Choice	2 <sup>nd</sup> Choice	3 <sup>rd</sup> Choice
Decreased drug usage			
Pain Relief			
Increase in your activity			
Better moods, behavior			
Other:			

21. If your treatment here does not bring you relief, what else would you consider trying?

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22. How do the following events or activities affect each of your pains?  
 Please place the pain letter s “A” “B” or “C” in the appropriate columns.

Activity	Better	Unchanged	Worse	Varies
Sitting				
Standing				
Walking				
Lifting				
Lying On Back				
Lying On Stomach				
Lying On Side				
House Work				
Sleeping				
Sexual Intercourse				
Coughing				
Voiding (Urinating)				
Bowel Movements				
Stress or Tension				
Eating				
Drinking				
Medications				
Liquor/ Wine / Beer				
Distractions (TV, Music.)				
Cold Weather				
Hot Weather				
Relaxation				
Exercise				
Massage				
Traction				
Heating Pad				
Ice Packs				

## DIAGNOSTIC STUDIES

(Very important to prevent unnecessary repetition of tests)  
X- Rays: List the most recent test for each area studied.

Area (Ex: Left Arm)	Date	Hospital or Clinic
1.		
2.		
3.		
4.		
5.		

CT SCANS (Cat Scans):  
(Ex: Left Arm)

Area	Date	Hospital or Clinic
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1.		
2.		
3.		
4.		
5.		

MRI Scans:  
Area (Ex: Lower Spine)

Area (Ex: Lower Spine)	Date	Hospital or Clinic
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1.		
2.		
3.		
4.		
5.		

Myelograms:  
Area (Ex: Neck)

Area (Ex: Neck)	Date	Hospital or Clinic
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1.		
2.		

Bone Scans:

Bone Scans:	Date	Hospital or Clinic
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1.		
2.		

EMG or NVC (Electromyograms or nerve conduction studies):

Area (Ex: Left arm)

Area (Ex: Left arm)	Date	Hospital or Clinic
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1.		
2.		



**Please attach additional sheets as needed.**

Physical Therapy Location	Date	Treatment or Modalities Used	Relief
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited

**Please attach additional sheets as needed.**

Chiropractor	Date	Treatment	Relief
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited

**Please attach additional sheets as needed.**

Psychological/ Education	Date	Counseling/ Therapy	Relief
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited

**Please attach additional sheets as needed.**

Other Treatment Centers or Professionals	Date	Treatment Rendered	Relief
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited

**Please attach additional sheets as needed.**

List all medications you have ever taken for your pain. If you are still taking the medication, write "Current" under Last Taken.

Medication/ Dose	How many?	How often?	Last Taken	Relief	Duration of Relief
Tylenol 325mg	2	Every 4 hours	Oct,1991	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	3 hours
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	

Medication/ Dose	How many?	How often?	Reason taking	Last taken
Ex: Ventolin 4mg	one	Twice a day	asthma	Today

Please list all additional medication s to which you have had an allergic reaction:

Medication	Allergic reaction	Last Taken
Ex: Aspirin	Rash	1978



7. How often your financial situation been affected by your pain?

0 1 2 3 4 5 6 7 8 9 10  
(Not at all) (Devastated)

8. If you are working, how has your performance been affected?

0 1 2 3 4 5 6 7 8 9 10  
(Not at all) (Severely impaired)

9. How fair your insurance company been in dealing with you?

0 1 2 3 4 5 6 7 8 9 10  
(Very good) (Jeopardized my care)

10. Have you retained the services of an attorney?  Yes  No

11. Do you have a lawsuit pending or have you settled a lawsuit over this condition?

Pending  Settled  None

12. Before developing my pain, my daily activities included repetitive:

- Lifting (Maximum weight: \_\_\_\_\_lbs.)
- Bending
- Twisting

13. Does your pain prevent you from participating in social activities?

0 1 2 3 4 5 6 7 8 9 10  
(Never) (Always)

14. Does your pain prevent you from participating in recreational activities?

0 1 2 3 4 5 6 7 8 9 10  
(Never) (Always)

15. Does your pain prevent you from participating in domestic activities  
(i.e., chores, projects, hobbies)?

0 1 2 3 4 5 6 7 8 9 10  
(Never) (Always)

16. Does your pain interfere with sexual activity?

0 1 2 3 4 5 6 7 8 9 10  
(Never) (Always)

17. Pain affects my sleep:

0 1 2 3 4 5 6 7 8 9 10  
(Sleep more) (Sleep less)

18. Pain affects my appetite:

0 1 2 3 4 5 6 7 8 9 10  
(Never) (Always)

### Health Habits

1. Have you used any of the following within the last year?

This information will be held strictly confidential.

ITEM	OCCASIONAL	REGULAR USE
Cigarettes		
Alcohol		
Coffee		
Marijuana		
Cocaine		
Narcotic pain medications		
Amphetamines (speed)		
Diet pills		
Sleeping pills		
Muscle Relaxants		
Anti-anxiety medications		
Hallucinogens (LSD, PCP)		
Other:		

2. Do you feel you have any problems with your weight?  Yes  No

3. Do you exercise daily?  Yes  No

4. In a typical day how many hours do you spend:

At work \_\_\_\_\_ Doing house work \_\_\_\_\_ Exercising \_\_\_\_\_  
 At home \_\_\_\_\_ Sleeping \_\_\_\_\_ Resting \_\_\_\_\_

5. Please complete the following checklist:			
Rashes/itches			
Boil's			
Hives			
Head/Neck/Eyes			
Frequent headaches			
Blurred vision			
Double vision			
Pain in eyes			
<b>Ears</b>	Past problem	Present problem	Comments
Dizziness			
Light-headed			
Ringing in ears			
Earaches			
Discharge from ears			
<b>Nose/Throat</b>	Past problem	Present problem	Comments
Frequent nosebleed			
Frequent head cold			
Sore throats			
Sinus Problems			
Hoarseness			
Taste difficulty			
Smell difficulty			
Swallowing difficulty			
<b>Respiratory</b>	Past problem	Present problem	Comments
Wheezing			
Asthma			
Hay fever			
Bronchitis			
Pneumonia			
Chronic cough			
<b>Metabolic</b>	Past problem	Present problem	Comments
Anemia			
Diabetes			
Cancer			
Thyroid high			

<b>Neurological</b>	Past problem	Present problem	Comments
Fainting or blackouts			
Convulsions			
<b>Cardiovascular</b>	Past problem	Present problem	Comments
Chest pains			
High blood pressure			
Breath Shortness			
Feet swelling			
Ankles swelling			
Circulation Poor			
Blood clot			
Bleeding			
Chest tightness			
Thumping in heart			
<b>Gastrointestinal</b>	Past problem	Present problem	Comments
Heartburn/Indigestion			
Loss of appetite			
Recent weight gain			
Recent weight loss			
Stomach ulcer			
Nausea/Vomiting			
Frequent constipation			
Frequent Diarrhea			
Hemorrhoids/Piles			
Painful/bowel/movements			
Chronic bloating			
Gas/Belching			
Hepatitis			
Colitis			
Gallstones			
Diverticulitis			
<b>Urinary</b>	Past problem	Present problem	Comments
Urinary infections			
Blood in urine			
<b>Musculoskeletal</b>	Past problem	Present problem	Comments
Swollen joints			
Muscular pain			
Joint pain			
Chronic back pain			

<b>**Women Only**</b>			
Irregular Periods			
Severe menstrual cramps			
Vaginal Infections			
<b>Other Problems:</b>			

Thank you very much for completing this rather lengthy questionnaire. Your answers will be most useful in helping us to understand you and your pain, as well as how you are different from other people who have similar types of problems, if there is anything else you think we should know at this time please feel free to use the space below.

Thank you!