



PATIENT ID  
HERE

# QUESTIONNAIRE

Page 1 of 3

Patient's Name \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other physicians consulted: \_\_\_\_\_ Phone: \_\_\_\_\_

When did your pain start? \_\_\_\_\_

How did your pain start?  Auto Accident  After Surgery  Fall (not at work)  Work Related  Other

Describe the problem: \_\_\_\_\_

### Briefly list

Treatments tried: \_\_\_\_\_

Injections tried: \_\_\_\_\_

Medications tried: \_\_\_\_\_

Physical therapy tried: \_\_\_\_\_

Have you had any previous

CT scans – when \_\_\_\_\_ facility name \_\_\_\_\_

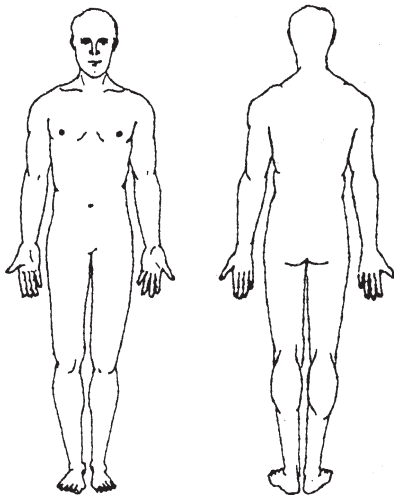
MRI – when \_\_\_\_\_ facility name \_\_\_\_\_

EMG – when \_\_\_\_\_ facility name \_\_\_\_\_

Bone scans – when \_\_\_\_\_ facility name \_\_\_\_\_

### **PLEASE HAVE THE REPORTS OF THESE STUDIES AVAILABLE WHEN YOU ARE SEEN**

### **PLEASE SHADE IN THE AREAS OF YOUR PAIN ON THE FIGURES BELOW.**



Please indicate on a scale of 0-10 what level your pain is, 0 = no pain, 10 = unbearable pain

#### PRESENT PAIN

0 1 2 3 4 5 6 7 8 9 10

#### USUAL PAIN

0 1 2 3 4 5 6 7 8 9 10

#### LEAST SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

#### WORST PAIN

0 1 2 3 4 5 6 7 8 9 10

In the last 2-3 weeks, how **often** has your pain occurred?

constant  intermittent  less than 8 hours a day  8-16 hours a day

What does your pain **feel like**? (check all that apply)

mild  burning  tingling  sharp  shooting  dull  aching

Other, please describe: \_\_\_\_\_

What **increases** your pain? (check all that apply)

work  walking  lying down  sitting  coughing  exercise  standing  sneezing

Other, please describe: \_\_\_\_\_



# QUESTIONNAIRE

PATIENT ID  
HERE

What **decreases** your pain? (*check all that apply*)

- not working
- walking
- heat
- medication
- exercising
- sitting
- lying down
- stretching
- TENS
- physical therapy
- standing
- resting
- cold
- injections

Other, please describe: \_\_\_\_\_

Do you have any numbness?  Yes  No

Do you have any weakness?  Yes  No

Does it keep you from falling asleep at night?  Yes  No

Do you have any changes in your bowel/bladder?  Yes  No

How often do you use the emergency room for pain control? \_\_\_\_\_

### Past and Present Medical Problems:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Lyme	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Please list **all surgeries** you have had:

Date	Surgery	Physician

Do you use anticoagulants/blood thinners?  yes  no - (*circle which one*)

Heparin Coumadin Plavix Lovenox Fragmin Other: \_\_\_\_\_

### Allergies:

#### Social History

Do you smoke?  yes  no \_\_\_\_\_ packs per day. If stopped, when? \_\_\_\_\_

Do you consume alcohol?  yes  no How much? \_\_\_\_\_

Have you ever felt you should cut down on your drinking?  yes  no

Have people annoyed you by criticizing your drinking?  yes  no

Have you ever felt bad or guilty about your drinking?  yes  no

Do you consume caffeinated beverages?  yes  no – How much? \_\_\_\_\_

Do you take prescription pain medication?  yes  no

If yes, do you take more than the prescribed amount?  yes  no

Have you ever been treated for substance abuse?  yes  no – Describe details \_\_\_\_\_

Are you married?  yes  no  divorced  widowed Do you live alone?  yes  no

Are you a caregiver to anyone?  yes  no

Is there someone at home who can help you with activities of daily living?  yes  no

Are you working?  yes  no

Occupation and description of job: \_\_\_\_\_

If not working:

Date last worked: \_\_\_\_\_

Is your pain keeping you from working?  yes  no

Do you feel you are able to return to work?  yes  no

Who released you from work? \_\_\_\_\_

When are you scheduled to return? \_\_\_\_\_

Are you on Worker's Comp?  yes  no Date started \_\_\_\_\_

Are you on Disability?  yes  no Date started \_\_\_\_\_

What type of Disability do you have:  short term  long term  social security  other

What is the medical diagnosis for this disability? \_\_\_\_\_



# QUESTIONNAIRE

Page 3 of 3

PATIENT ID  
HERE

## Family History

Is your father alive?  yes  no: Cause of death \_\_\_\_\_

What health problems does your father have? \_\_\_\_\_

Is your mother alive?  yes  no: Cause of death \_\_\_\_\_

What health problems does your mother have? \_\_\_\_\_

Do you have any blood relatives/children/siblings with significant medical problems?  yes  no

Explain: \_\_\_\_\_

## Behavioral Health

How has the pain affected your personality? Check all that apply:

- no effect
- slightly upset
- moderately upset
- severely upset
- irritable
- anxious
- moody
- withdrawn
- unmotivated

What stress has the pain caused you at home/work?

\_\_\_\_\_

Are you depressed now?  yes  no

Do you have thoughts of suicide?  yes  no

Do you want to see a behavioral health specialist to help you deal with the pain?  yes  no

Have you ever seen a counselor, psychologist, or psychiatrist?  yes  no

Please include their name, date last seen, and office number.

\_\_\_\_\_

What type of behavioral health treatment have you tried?

- ECT
- Counseling
- Medication
- Group Therapy
- Biofeedback
- Other \_\_\_\_\_

## Check any Health issues that apply to you.

**Constitutional:**  weight loss  excess fatigue  chills  fever  night sweats  loss of appetite

**Eyes:**  glasses/contacts  vision changes  eye pain  tearing

**ENT/mouth:**  earache  ringing in the ears  hearing loss  infections  sore throat  post nasal drip  
 bleeding gums

**Cardiovascular:**  chest pain  angina  palpitations  short of breath with activity  heart murmur

**Pulmonary:**  cough  productive cough  wheezing  short of breath at rest  asthma  TB

**Gastrointestinal:**  heartburn  peptic ulcers  nausea  vomiting  diarrhea  constipation  bloating  
 laxative use  jaundice  loss of bowel control

**Urological:**  frequent urination  urinary tract infection  painful urination  urinary retention  urinary dribbling  
 loss of urinary control

**Musculoskeletal:**  joint pain  joint swelling  joint stiffness  muscle pain  muscle stiffness

**Endocrine:**  hot flashes  hair loss  always hot  always cold  always thirsty

**Skin:**  itching  rash  infection

**Blood:**  easy bruising  easy bleeding  anemia  swollen lymph nodes

**Immune compromise:**  AIDS  steroid use  frequent infections  chemotherapy

**Neurological:**  numbness  tingling  tremor  fainting  headaches  weakness  dizziness

**Psychological:**  anxiety  depression  insomnia  nightmares

**For men only:** do you have problems with erections?  yes  no

**For women only:** could you be pregnant now?  yes  no date of last menstrual period \_\_\_\_\_