

Date: _____

PAIN QUESTIONNAIRE

Name: _____ Date of birth: _____ Age: _____

Who referred you to this practice? (newspaper, TV, doctor, friend etc..) _____

Who is your primary care physician: _____

Where is your pain? _____

When did the pain start? _____

How did the pain start? _____

*Was your pain due to an accident or major trauma (car accident, fall, job related injury, etc.)?
If so please explain on last page.*

FOR NURSE USE ONLY: VITAL SIGNS

B/P: _____ HR: _____ RR: _____ T: _____

HEIGHT: _____ WEIGHT: _____

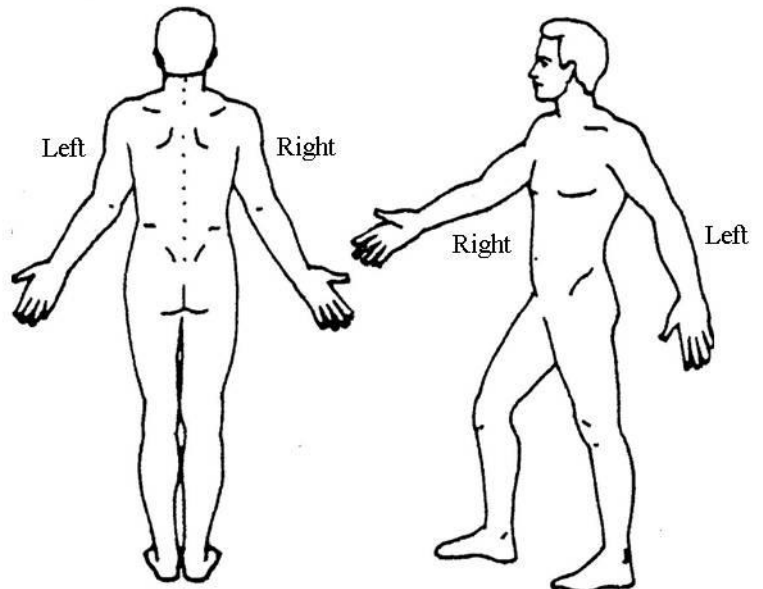
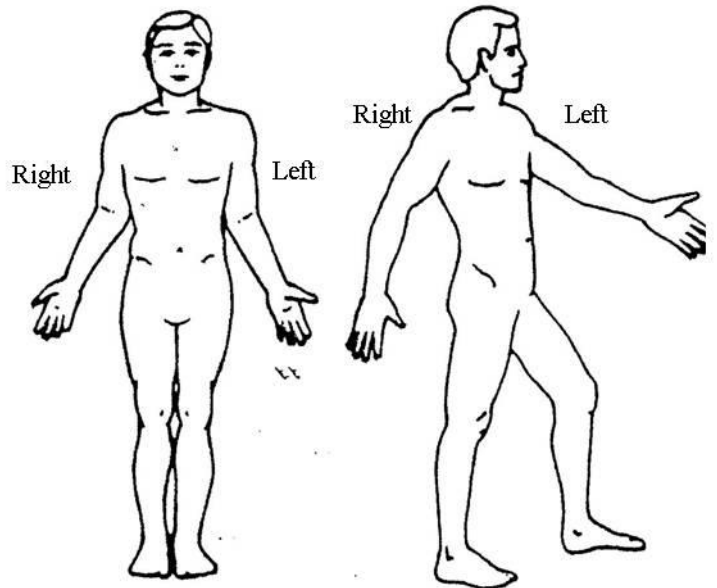
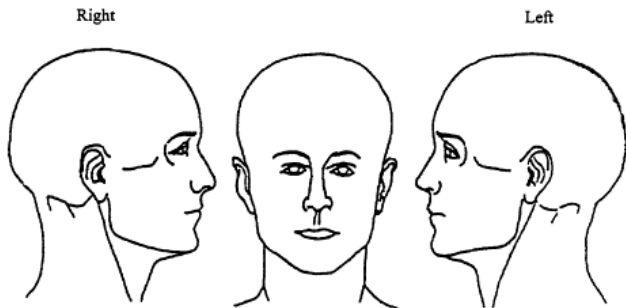
Nurse Comments: _____

Nurse Signature: _____ Date: _____

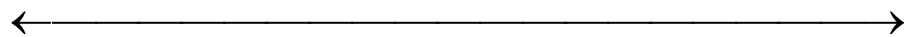
Name: _____

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Please SHADE IN your painful areas on the diagrams below.



PAIN SCALE VAS: 0 1 2 3 4 5 6 7 8 9 10



No
Pain

Moderate
Pain

Worst
Possible Pain

Using the pain scale above (0 – 10), please give a number to the pain you experience doing the following things:

Resting pain level (sitting, lying down): _____

Daily activity pain level (while walking, standing, dressing, etc.): _____

Strenuous activity pain level: _____ What activity? _____

Average pain level: _____

Using the same pain scale (0-10) what do you feel is an acceptable pain level for you? _____

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Do you experience any of these symptoms?

- | | | |
|------------------------------------|--|-----------------|
| Weakness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Numbness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Tingling (pins & needles)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Changes in skin color? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Cold skin? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Loss of bowel control? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: _____ |
| Loss of bladder control? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: _____ |
| Male impotence? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dropping things? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Fever? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Recent or unexplained weight loss? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

What activities increase your pain?

- | | | |
|----------------------|--|-----------------|
| Sitting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Walking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Laying down? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Standing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Lifting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How much? _____ |
| Bending backward? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Heat? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Ice? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Weather? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Emotions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Work? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sneezing / Coughing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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What activities decrease your pain?

- | | | |
|----------------------|--|-----------------|
| Sitting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Walking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Laying down? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Standing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How long? _____ |
| Lifting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How much? _____ |
| Bending backward? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Heat? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Ice? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Weather? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Emotions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Work? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sneezing / Coughing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Do you take medications to decrease your pain? Yes No

Please list? _____

What time of day do you experience the most pain? _____

How often? Occasional/Episodic Constant Only at night

Please check “Yes” to those that apply to your pain description.

Please be sure to include the location of the type of pain.

- | | | |
|------------------|--|-----------------|
| Burning? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Stabbing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Electric shocks? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Spasm? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Sharp? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Aching? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Throbbing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Dull? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Radiating? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |
| Vice like? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Location: _____ |

Other (please describe): _____

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Please describe treatments you have tried for your specific pain problem in the past and what effects they have had on your pain:

<u>Treatment</u>	<u>When</u>	<u>Where</u>	<u>Improvement</u>	<u>Worsened</u>	<u>No Change</u>
Surgery					
Medications					
Physical therapy					
Chiropractic					
Brace					
Acupuncture					
Injections					
Pain Program					
Other					

Please check the tests you have had for this problem and indicate when and where they were done and of what part of your body:

<u>Test</u>	<u>Of What</u>	<u>When</u>	<u>Where</u>
<input type="checkbox"/> X-RAY			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CAT SCAN			
<input type="checkbox"/> MYELOGRAM			
<input type="checkbox"/> EMG			
<input type="checkbox"/> BONE SCAN			
<input type="checkbox"/> DISCOGRAM			

Other _____

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Allergies (Please list allergens and describe what happened.)

<i>Allergen</i>	<i>Reaction</i>

Have you ever had an allergic reaction to:

Contrast Dye? Yes No

Describe Reaction: _____

Cortisone/Steroids? Yes No

Describe Reaction: _____

Local anesthetics (Novacaine, Xylocaine) Yes No

Describe Reaction: _____

Please list your **Prescription** medications, including **Pain** medicine and any **other** (high blood pressure medication, diabetes medications, eye or ear drops, inhalers, etc.)

Birth control method (female): _____

MEDICATION	DOSE	TIMES DAILY	PRESCRIBING DOCTOR

Please list any **other medications** you are taking: (Including ASPIRIN, Anti-inflammatory medications such as Advil, Aleve, Tylenol, etc...)

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Are you taking **blood thinners**? Yes No

If so, why? _____

Please list any medications that you felt **helped** your pain: _____

Please list any medications tried that **were not helpful**: _____

Past Medical History

Please check any of the following conditions you have had or presently do have:

- Diabetes
- Arthritis
- Cancer
- Ulcer
- Kidney problems
- Respiratory problems
- Bleeding problem
(blood thinner, clotting problem)
- Infectious disease
(Hepatitis)
- Seizures
- High blood pressure
- Neurogenic disease
- Stroke

Please list any surgeries you have had, including when and where:

<u>Surgery type</u>	<u>When</u>	<u>Where</u>

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Family History / Illness / Diseases:

	<u>Back Problems</u>	<u>Diabetes</u>	<u>Osteoporosis</u>	<u>Arthritis</u>	<u>Other</u>
Mother					
Father					
Children					
Siblings					
Other					

Personal History

Do you smoke or use tobacco? Yes No (How much) _____ (How long) _____

Do you drink alcohol? Yes No If Yes, how much? Daily _____ Weekly _____

Do you use illegal drugs? Yes No Have you in the past (explain) _____

Do you have a history of prescription drug *abuse*? _____

Have you had problems with alcohol or drug use? (DUI/loss of job /illness /injury/incarceration)

Are you pregnant or planning to become pregnant? Yes No N/A

What is your current marital status? Single Living with Partner Married Divorced Widowed

What is the highest level of education you've completed? _____

EMPLOYMENT STATUS:

Are you currently working? Yes (full time part time) No Retired

If yes, please describe your occupation including job tasks:

Has pain forced you to stop working or limited your capacity at work? _____

Work restrictions: _____

How long have you been off work or restricted at work due to pain? _____

Is this a Worker's Compensation case? Yes No

Is there litigation involved? Yes No

Do you exercise? Regularly Occasionally Never Why?: _____

How do you sleep? Enough Not enough Interrupted by pain

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Currently do you have any of the following conditions:

Skin:

- None
- Lumps _____
- Dry skin
- Changes in appearance of texture
- Changes in color
- Rashes _____
- Sweaty skin
- Changes to hair or nails

Nose/Mouth/Throat:

- None
- Sores/ulcers
- Sinus problems
- Neck pain/stiffness/swelling
- Voice changes
- Difficulty or pain swallowing
- Other _____

Nervous System:

- None
- Insomnia
- Depression
- Nervousness
- Panic attacks
- Psychiatric disorder _____
- Head trauma
- Seizures/epilepsy
- Dizziness/lightheadedness
- Tremors/shaking
- Fainting spells
- Stroke/mini-stroke
- Chemical dependency: kind _____
- Memory loss
- Other _____

Digestive System:

- None
- Change in bowel habits
- Heartburn/ulcers
- Blood in stool
- Nausea/vomiting
- Constipation

Respiratory System:

- None
- Shortness of breath
- Heavy cough
- Coughing up blood
- Emphysema/Bronchitis
- Asthma
- T.B. (Tuberculosis)
- Other _____

Vision/Hearing:

- None
- Decreased vision
- Cataracts
- Glaucoma
- Decreased hearing
- Ringing in the ears
- Other _____

Cardiovascular System:

- None
- Previous heart attack
- Chest pain
- Irregular heart beats/palpitations
- Congestive heart failure
- Heart valve problems
- Swelling/edema _____
- High blood pressure
- Bleeding/bruising
- Blood clots _____
- Pacemaker
- Anemia
- Poor circulation
- Rheumatic fever
- Other _____

Reproductive System:

- None
- Pregnant/trying to become pregnant
- Female organ problems
- Sexually transmitted diseases
- Unusual penis or vaginal discharge
- Impotence/loss of libido

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Liver/Pancreas/Thyroid/Glands:

- None
- Yellow eyes
- Diabetes
- Thyroid disorder
- Heat intolerance
- Cold intolerance
- Swollen glands
- Hepatitis/liver disorder
- Excessive thirst or hunger
- Excessive sweating
- Other _____

General:

- None
- Fever
- Chills
- Night sweats
- Severe fatigue
- Generalized weakness
- Loss of Appetite
- Undesired weight loss
- Tumor/Cancer _____
- HIV/AIDS
- Tick bite reaction
- Recent cold or other illness
- Increased appetite
- Undesired weight gain
- Other _____

Other _____

Urinary System:

- None
- Frequent urination
- Difficulty starting urination
- Painful urination
- Urinary retention
- Blood in urine
- Kidney stones
- Women:** Urinary stress incontinence
- Men:** Abnormal prostate condition
- Other _____

Joints:

- None
- Arthritis (where) _____
- Stiffness (where) _____
- Swelling (where) _____
- Other _____

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I hereby confirm that all the above information is true to the best of my knowledge. I give consent to history taking and physical examination by Spine Pain Diagnostics Associates physicians and their designees.

(Signature of **patient** OR **legal representative**)

Person assisting with filing out this questionnaire _____

Comments: _____

If your pain is **a result of an injury**? If so please explain what happened:

Date of injury: _____

Motor vehicle accident? Yes No

Work related? Yes No

Are you in litigation? Yes No

Mechanism of injury (What happened: If car accident, how fast, where were you sitting, where you belted in, was there damage to the car, etc...)

Did you have pain immediately? Yes No

Did you seek treatment immediately? Yes No Where/What? _____

What type of treatments have you had for this pain? _____ Where? _____

What? _____

If a police report was filed please attach copy and any other records pertinent to this case

Signature _____

Name: _____

Date of Birth: _____