

PAIN MANAGEMENT CENTER - PATIENT QUESTIONNAIRE

Appointment date: ____ / ____ / ____ Time: _____

First name: _____ M.I.: _____ Last name: _____

Primary care physician name (PCP): _____ PCP phone number: _____ Date of last visit to PCP:
Dr. _____ - _____ - _____ Month: _____ Year: _____

Referring physician (if other than PCP): Dr. _____ Referring physician phone number: _____ - _____ - _____

Date Pain started: Day _____ Month _____ Year _____

Briefly describe your primary pain complaint: _____

Do you have pain in other locations? Yes No If yes, please specify: _____

Pain radiates to my: (choose all that apply) <input type="checkbox"/> Head <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Abdomen <input type="checkbox"/> Leg	Type of pain: (choose all that apply) <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Numbness <input type="checkbox"/> Stabbing <input type="checkbox"/> Tingling	Pain characteristics: (choose one) <input type="checkbox"/> Right side <input type="checkbox"/> Middle only <input type="checkbox"/> Left side <input type="checkbox"/> Everywhere <input type="checkbox"/> Both sides
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Pain caused by: <input type="checkbox"/> No specific event <input type="checkbox"/> Work injury <input type="checkbox"/> Car accident <input type="checkbox"/> Surgery Other cause: _____	If work injury: Date: _____ Ins Co: _____ Case manager: _____ Claim #: _____	Did you hire an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No Is a lawsuit pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain pattern: <input type="checkbox"/> Continuous <input type="checkbox"/> Comes and goes <input type="checkbox"/> Brief/momentary
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Choose the number that describes your pain: (0 = no pain and 10 = worst pain imaginable) _____ /10 - Pain intensity now _____ /10 - Pain at its worst _____ /10 - Pain at its least _____ /10 - Pain on average	Rate the quality of your sleep: _____ /10 (0 = Not at all restful and 10 = Completely restful) Do you have difficulty GETTING to sleep? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have difficulty STAYING asleep? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Where is your pain?
Using the symbols listed below, mark on the drawing the areas where you feel your pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

SYMBOLS

----- Numbness

0000 Pins and needles

xxxx Burning

//////// Stabbing

++++ Aching

E External (on or outside the body)

I Internal (inside the body)

Do not write below this line.



PERSONAL HEALTH HISTORY

Please indicate whether you currently have [C], or previously have had [P], any of the following conditions. All information is strictly confidential.

		C	P			C	P			C	P
Constitutional Symptoms	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Brain/Nerves	Headache	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>		Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Eye	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Supplement Use	<input type="checkbox"/>	<input type="checkbox"/>	Seizures		<input type="checkbox"/>	<input type="checkbox"/>	
	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>
	Eye Discharge	<input type="checkbox"/>	<input type="checkbox"/>		Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		Tremors	<input type="checkbox"/>	<input type="checkbox"/>
	Glasses or Contacts	<input type="checkbox"/>	<input type="checkbox"/>		Abnormal Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>		Weakness/Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>		Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>		Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ear	Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>		Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Loss of Coordination	<input type="checkbox"/>	<input type="checkbox"/>
	Ringling or Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss		<input type="checkbox"/>	<input type="checkbox"/>	
	Hearing Difficulty/Aids	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's		<input type="checkbox"/>	<input type="checkbox"/>	
Nose	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	Painful Breathing	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>
	Discharge	<input type="checkbox"/>	<input type="checkbox"/>		Productive Cough	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
	Congestion	<input type="checkbox"/>	<input type="checkbox"/>		Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	
	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of Suicide	<input type="checkbox"/>	<input type="checkbox"/>	
	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth/Throat	Denture	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood/Glands	Sweats	<input type="checkbox"/>	<input type="checkbox"/>
	Jaw/Tooth Pain	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease		<input type="checkbox"/>	<input type="checkbox"/>	
	Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	
	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Muscles/Joints	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>		Bursitis	<input type="checkbox"/>	<input type="checkbox"/>		Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Genitals/Bladder	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>		Poor Posture	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficult Urination	<input type="checkbox"/>	<input type="checkbox"/>		Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/ Other	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>		Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>		Allergies (other than drugs)	<input type="checkbox"/>	<input type="checkbox"/>
	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Cancer		<input type="checkbox"/>	<input type="checkbox"/>	
	Testicle Problem	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV		<input type="checkbox"/>	<input type="checkbox"/>	
	Flank Pain	<input type="checkbox"/>	<input type="checkbox"/>	Previous Back Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Lupus		<input type="checkbox"/>	<input type="checkbox"/>	
	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pain and/or Numbness	Arms	<input type="checkbox"/>	<input type="checkbox"/>		Stomach/Bowels	Abdominal Pain	<input type="checkbox"/>
	Nocturia	<input type="checkbox"/>	<input type="checkbox"/>		Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn		<input type="checkbox"/>	<input type="checkbox"/>
	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>		Hands	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia		<input type="checkbox"/>	<input type="checkbox"/>
	Congested Breasts	<input type="checkbox"/>	<input type="checkbox"/>		Elbows	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting		<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Neck		<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>		<input type="checkbox"/>	
Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Hip		<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>		<input type="checkbox"/>	
Excessive Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	Legs		<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>		<input type="checkbox"/>	
Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Lumps in Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	Black, Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>			
Menopause	<input type="checkbox"/>	<input type="checkbox"/>	Tailbone	<input type="checkbox"/>	<input type="checkbox"/>	Skin/Breast	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>		
Painful Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	Skin/Breast	Skin Rash	<input type="checkbox"/>		<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>		Itching	<input type="checkbox"/>		<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	
Pain on Intercourse	<input type="checkbox"/>	<input type="checkbox"/>		Bruise Easily	<input type="checkbox"/>		<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		Shingles	<input type="checkbox"/>		<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
				Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>					

Do Not Write Below This Line



FAMILY MEDICAL HISTORY

Has anyone in your family ever had any of the following conditions?
 Please check all that apply:

SOCIAL HISTORY

SUBSTANCE USE	QUANTITY	
Beers	_____	per day / week
Alcoholic Beverages	_____	per day / week
Use of Tobacco	_____	per day / week
Illegal Drugs	_____	per day / week

Retired
 Employed
 Unemployed

Marital Status: _____

Occupation: _____

	Father	Mother	Brother	Sister	Grandparent
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

~ PHYSICIAN USE ONLY ~

DO NOT WRITE IN THIS SPACE.

CC:

Pain Character:

Constant / Intermittent

Current: _____ / 10 Best: _____ / 10

Worst: _____ / 10

Motor Deficit: Yes No _____

Sensory Deficit: Yes No _____

Bowel / Bladder Incontinence: _____

Past Treatments: _____

Reviewed with patient Date: _____ Physician's Signature: _____

Do Not Write Below This Line

