Comprehensive Pain Management Questionnaire

For office use only

Patient I.D.

Your Name:_____ Today's Date:_____

Referred by: □ Physician Name:_____
□ Self-Referral How did you hear about us?_____
□ Other Who?_____

Date of birth:_____ Age:_____ Sex: □ Male □ Female

Occupation:_____

Address:_____
City:_____ State:_____ Zip:_____
Telephone: Home:(_____)_____ Work: (_____)_____

Is your condition job related? □ Yes □ No

Who should we send reports to?_____ Phone: (_____)_____

Physician:_____ Address:_____
_____
_____
Phone (_____)_____

Physician:_____ Address:_____
_____
_____
Phone (_____)_____

Physician:_____ Address:_____
_____
_____
Phone (_____)_____

Attorney:_____ Address:_____
_____
_____
Phone (_____)_____

Case Manager:_____ Address:_____
_____
_____
Phone (_____)_____

Are you currently in litagation? □ Yes □ No

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Describe the purpose of your visit and the major problems needing help:

Describe any other problems that need help:

HPI

How did your pain first start?

- □ Suddenly
- □ Gradually
- □ Lifting
- □ Twisting
- □ Fall
- □ Bending
- □ Other:
- □ Pulling
- □ Injured at work
- □ Auto accident
- □ Hit from behind
- □ Sports
- □ No apparent cause

When did this pain start? (Approximate date):

Where is your pain?

Describe what the pain feels like:

Where does is spread to?

Is your pain: □ Intermittent? □ Constant?

When it happens, how long does the severe pain last?
Seconds____Minutes_____Hours_____

How many hours per day do you have pain?

In the past, did you ever have similar pain? (Approximate date):

How many times in the past 12 months have you been to an emergency room (ER) for treatment of your pain?

What makes your pain ***worse***?

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□ During exercise	□ Stress	□ Bending forward
□ After exercise	□ Sex	□ Bending backward
□ Sitting	□ Morning	□ Coughing
□ Standing	□ Night	□ Sneezing
□ Walking	□ Fatigue	□ Touching skin
□ Damp weather	□ Cold weather	□ Work

□ Other:_____

What makes your pain ***less***?

□ Lying down	□ Physical therapy
□ Sitting	□ Alcohol
□ Standing	□ Pain pills
□ Walking	□ Injections
□ Aspirin	□ Exercise
□ Heat	□ Ice
□ Nothing	□ Advil type pills

□ Other:_____

What pain treatments have you tried?	Did it help?	
□ Surgery	□ Yes	□ No
□ Medications	□ Yes	□ No
□ Physical Therapy	□ Yes	□ No
□ Trigger Point Injections	□ Yes	□ No
□ Acupuncture	□ Yes	□ No
□ Epidural Injections	□ Yes	□ No
□ TENS (electronic nerve stimulator)	□ Yes	□ No
□ Psychology / Counseling	□ Yes	□ No
□ Biofeedback / Relaxation Techniques	□ Yes	□ No
□ Group Therapy	□ Yes	□ No
□ Pain Management Program	□ Yes	□ No
□ Nerve Blocks	□ Yes	□ No
□ Other:_____	□ Yes	□ No

Pain Level:

Please mark this line with the intensity of your pain using all of the following letters:

P – present pain
W – Worst it gets
M – Most of the time
L – Least it gets

No pain | - - - - - | - - - - - | - - - - - | - - - - - | - - - - - | - - - - - | - - - - - | - - - - - | - - - - - | - - - - - | Worst pain
0 1 2 3 4 5 6 7 8 9 10

Have you had any tests for your problem?

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X-rays	☐ Yes	☐ No	Date:_____
CAT Scan	☐ Yes	☐ No	Date:_____
MRI	☐ Yes	☐ No	Date:_____
EMG / Nerve test	☐ Yes	☐ No	Date:_____
Myelogram	☐ Yes	☐ No	Date:_____
Bone Scan	☐ Yes	☐ No	Date:_____
Discogram	☐ Yes	☐ No	Date:_____
Special Injections	☐ Yes	☐ No	Date:_____

Other physicians or health care providers that you have seen or are seeing:
(including chiropractors, therapists, etc.)

Name	Specialty	Address
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____

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What you can do now:

□ Drive □ Walk 1 block □ Housework
□ Climb Stairs □ Work at job

How many hours do you spend in bed due to pain? (excluding sleep time):_____

Describe in your own words how you spend an average day:_____

Rx

Allergies to medications: _____

Any other allergies: _____

Medicine that you take ***now***:
(including non prescription or vitamins)

Name(s)	Why taken? (pain, heart, etc.)	How much? (dose in 24 hrs)	Date started	Prescribing MD	Does it help?

Are there any side effects? _____

Do you take blood thinners (coumadin)? □ Yes □ No

Medicine(s) that you tried in the past:

Names:	Side Effects:

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General Medical Problems:

A.	Cancer History	☐	I.	Diabetes	☐
B.	Heart Disease	☐	J.	Epilepsy (seizures)	☐
C.	Lungs, asthma	☐	K.	Bowel or bladder	☐
D.	Liver, hepatitis	☐	L.	Arthritis	☐
E.	Bleeding Disorder	☐	M.	Migraines	☐
F.	Stomach, intestines, ulcer	☐	N.	Other:_____	☐
G.	High blood pressure	☐	O.	Other:_____	☐
H.	HIV Status (-) (+) (unk)	☐			

Hospitalizations:

Year	Name of hospital / address	Problem and treatment

Important accidents or broken bones:

Year	Injury suffered	Treatments

ROS

Respiratory	(circle one)	
Do you have any breathing problems?	Yes	No
Do you get repeated chest infections?	Yes	No
Have you coughed up blood or sputum?	Yes	No
Have you had pneumonia or pleurisy?	Yes	No
Do you suffer from any respiratory diseases?	Yes	No

Cardiovascular

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Have you had heart trouble?	Yes	No
Have you ever had high blood pressure?	Yes	No
Do you have pains in the heart or chest?	Yes	No
Do you easily become short of breath?	Yes	No
Are your ankles often swollen?	Yes	No
Do leg pains sometimes stop you from walking?	Yes	No
Have you ever had phlebitis or vein trouble?	Yes	No
Do you have a bleeding problem?	Yes	No

G.I. / G.U.

Do you have any swallowing problems?	Yes	No
Have you had a weight loss or gain of more than 10 pounds in the past year?	Yes	No
Have you ever had a stomach ulcer?	Yes	No
Have you ever vomited blood?	Yes	No
Do you have trouble with constipation?	Yes	No
Do you use suppositories or stool softeners regularly?	Yes	No
Do you take laxatives or enemas regularly?	Yes	No
Do you have trouble with diarrhea?	Yes	No
Have you ever had black tarry stools?	Yes	No
Have you ever had a hernia (rupture)?	Yes	No
Do you dribble urine or use a catheter?	Yes	No
Have you passed blood in your urine?	Yes	No
Do you have frequent chills or fever?	Yes	No
Does it burn when you pass your urine?	Yes	No
Have you had a kidney infection?	Yes	No

G.I. / G.U. (continued)

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Have you ever had kidney or bladder stones? Yes No

Do you have problems with erections / intercourse? Yes No

Gynecologic (women only)

Give the date of your last menstrual period:_____

Do you have any problems with your menstrual period? Yes No

Are you taking birth control pills? Yes No

Give the date of your last PAP smear:_____

Endocrine

Have you ever had diabetes (high blood sugar)? Yes No

Have you had thyroid trouble? Yes No

Immune

Do you catch infections easily? Yes No

Have you ever had an HIV test? Yes No

Have you ever taken any recreational drugs? Yes No
If yes, when? _____ If yes, which drugs? _____

Do you have trouble healing? Yes No

Do you have any skin problems? Yes No

Skeletal

Do you have any joint stiffness, pain or swelling? Yes No

Do you have neck pain? Yes No

Do you have back pain? Yes No

Do you have gout? Yes No

Neurological

Do you have seizures or take medications to control seizures? Yes No

Neurological (continued)

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Do you have fainting spells or dizziness?	Yes	No
Do you have severe headaches?	Yes	No
Do you have weakness or numbness of your arms or legs?	Yes	No
Do you have any learning problems?	Yes	No
Have you ever had a stroke?	Yes	No
Did you ever have a head injury?	Yes	No

Well Being

Have you been less social lately?	Yes	No
Are you often preoccupied with your pain?	Yes	No
Are you a nervous or anxious person?	Yes	No
Have you been more irritable or temperamental lately?	Yes	No
Have you been feeling sad or depressed?	Yes	No
Do people often make you angry?	Yes	No
Have you every been treated by a psychiatrist or been in psychotherapy? If yes, when? _____	Yes	No
Are you finding fewer enjoyable things to do?	Yes	No
In the past year, have you had thoughts of suicide?	Yes	No

Sleep Hours per night? _____

Do you have trouble falling asleep?	Yes	No
Do you have trouble staying asleep?	Yes	No
Does pain awaken you?	Yes	No
Do you have trouble with memory or concentration?	Yes	No
Is your appetite poor?	Yes	No
Are you less interested in sex?	Yes	No

Height:_____ Weight:_____
Weight one year ago:_____ My normal weight is:_____

Family and social history

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Last grade you finished in school?_____

List types of jobs in the past:_____

_____

_____

Do you know anyone in your family or friends who has suffered from a similar problem to yours?_____

_____

What diseases run in your family?_____

_____

Is there anyone disabled among your family or friends?_____

Ages and health of children:_____

_____

_____

_____

How many people live in your household?_____

Who are they?	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? □ Yes □ No If so, how much?_____

Were you a smoker? □ Yes □ No When did you quit?_____

Do you ever drink alcohol? □ Yes □ No How much?_____

Have you had a drink in the past 24 hours? □ Yes □ No

Ever had a problem related to alcohol? (e.g. DUI, injury, break-up, etc.) □ Yes □ No

Were you ever a heavy drinker? □ Yes □ No

Do you drink coffee? □ Yes □ No Cups per day:_____

Do you drink cola? □ Yes □ No Cups per day:_____

What would you be doing if you didn't have pain?

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Any other information that would help us understand your problem?

Some of the words below describe your ***present*** pain; some do not.

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- Circle a word only if it describes your pain.
- If a category does not describe your pain, please leave it blank.
- Do not circle more than one word per category.

(Note: If you have more than one pain problem, use the words below to describe your worst pain problem.)

1	**2**	**3**	**4**
Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing		Stabbing	
Beating		Lancinating	

5	**6**	**7**	**8**
Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			

9	**10**	**11**	**12**
Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			

13	**14**	**15**	**16**
Fearful	Punishing	Wretched	Annoying
Frightful	Grueling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable

17	**18**	**19**	**20**
Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing		Dreadful
	Tearing		Torturing

Where is your pain?

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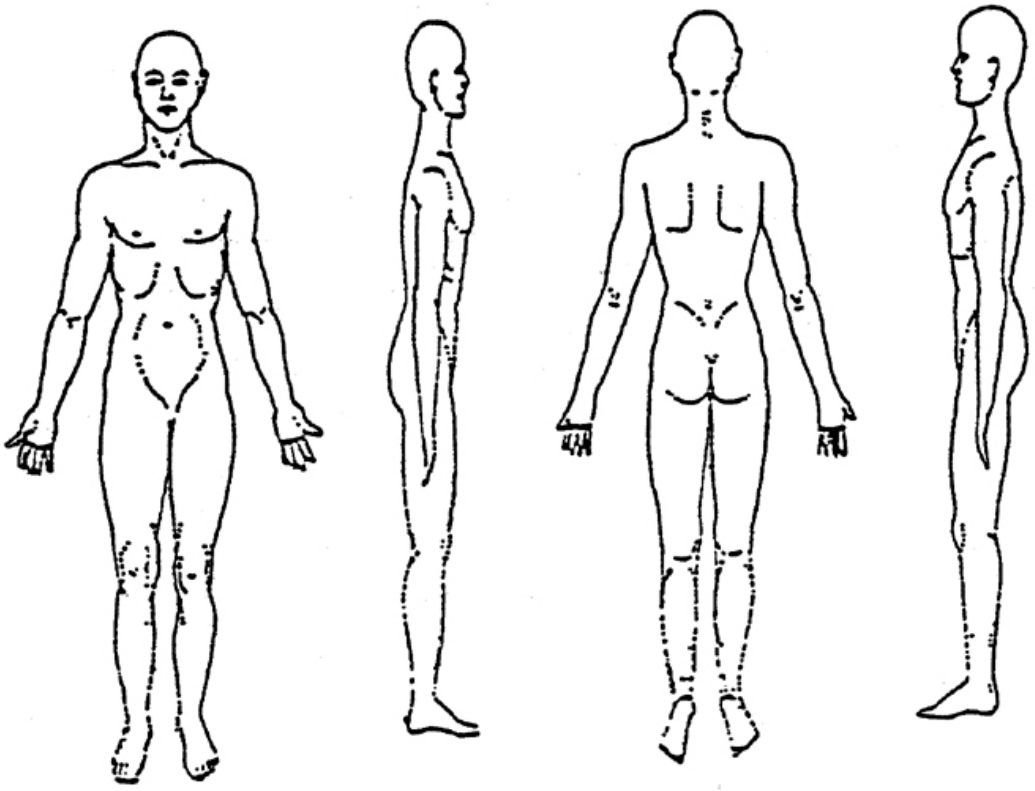
= Severe

= Moderate

= Mild

Use ***arrows*** to show where pain radiates or travels to.



The attached form has been reviewed with the patient.

Physician comments:

Physician's Signature

Date