Initial Pain Questionnaire

Date: ________________________

Name: ____

Last First Middle Initial

Address: ____

Street Address City State Zip

Home Phone ____________________ Cell :____________________ Work:____________________

Referring Physician:____

Other Physicians: ____

Age: _____________

PAIN HISTORY:

What is the main problem for which you are seeking treatment?

____

How long have you had your current pain?

____________Years ____________ Months ____________ Weeks

ONSET OF PAIN: How did your pain start?

- ☐ Injury at Work Injury,
- ☐ not at work Motor
- ☐ Vehicle Accident Illness,
- ☐ non-injury
- ☐ Treatment caused (e.g. radiation, surgery, etc)
- ☐ Undetermined

If there is a precipitating event not mentioned, what was it?__________________________________

____

____

____

____

____

PAIN INTENSITY:
Circle Your Average Level of Pain In the Past Week (0 is no pain and 10 is severe):

0 1 2 3 4 5 6 7 8 9 10

Using the same scale, what is your lowest pain score____________ highest?____________

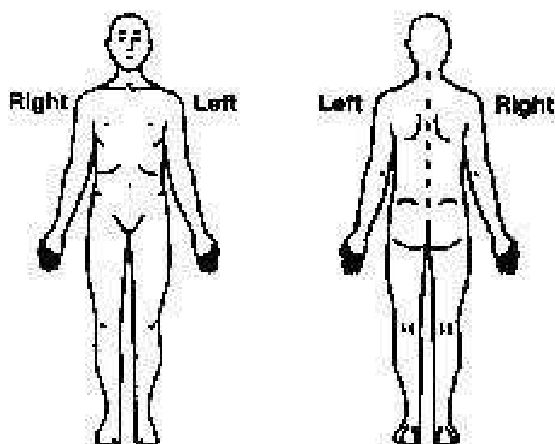
TIMING OF PAIN: How often do you have pain (please check one)?
- ☐ Constantly (100% of time)
- ☐ Nearly constantly (60 to 95% of the time)
- ☐ Intermittently (30 to 60% of the time)
- ☐ Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst ?
- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night
- ☐ No typical pattern

PAIN/ SYMPTOM QUALITY: How would you describe your pain (please check all that apply):
☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing ☐ Cramping
☐ Dull/Aching ☐ Shooting ☐ Pressure-like ☐ Other:___________
Do you have numbness (loss of sensation)? If so, where: ______________________________
Do you have pins and needles? If so, where: ______________________________
Do you have weakness? If so, where: ______________________________

Have you had fall in the last month? ☐YES ☐NO

PAIN LOCATION: Please mark the location(s) of your pain on the diagram with an "x." If whole areas are painful, please shade in these areas.



RELIEVING AND AGGRAVATING FACTORS:
How do the following affect your pain? Please check one for each item.

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
BOWEL MOVEMENTS			
COUGHING/ SNEEZING			

ACTI VITIES AND PAIN
How many blocks can you walk? ______________________________

How many minutes or hours can you walk? ______________________________

How many minutes or hours can you stand? ______________________________

To assist walking, I use a : ☐ Cane ☐ Walker ☐ Wheelchair ☐ No assistance device

Are you NOT able to perform any of the following activities?

☐ Going to Work ☐ Household Chores ☐ Yard work or Shopping

☐ Socializing with Friends ☐ Exercising

PAIN TREATMENTS: Please check the responses to the treatment you have tried:

TREATMENT	**NO RELIEF**	**MODERATE RELIEF**	**EXCELLENT RELIEF**
Surgery			
Traction			
Injections			
Physical Therapy			
Exercise			
TENS			
Heat Treatment			
Ice Treatment			
Psychotherapy			
Acupuncture			
Hypnosis			
Biofeedback			
Chiropractic Therapy			

PAIN MEDICATIONS TRIED: Please check all medication you have tried:

OPIOIDS:
- ☐Hydrocodone (Vicodin)
- ☐Codeine
- ☐Fentanyl (Duragesic)
- ☐Dilaudid (Exalgo)
- ☐Morphine/ MS Contin
- ☐Methadone
- ☐Oxycodone (Percocet)
- ☐Oxycontin
- ☐Butrans
- ☐Suboxone

NSAIDs
- ☐Tylenol
- ☐Aspirin
- ☐Motrin
- ☐Naproxen
- ☐Indocin
- ☐Relafen
- ☐Celebrex
- ☐Toradol
- ☐Meloxicam (Mobic)
- ☐Diclofenac
- ☐Vioxx

MUSCLE RELAXANTS
- ☐Soma
- ☐Flexeril
- ☐Baclofen
- ☐Zanaflex
- ☐Robaxin
- ☐Skelaxin
- ☐Valium (Diazepam)

ANTI DEPRESSANTS
- ☐Elavil (Amitryptilline)
- ☐Pamelor (Nortryptilline)
- ☐Desipramine
- ☐Imipramine
- ☐Zoloft
- ☐Paxil
- ☐Prozac
- ☐Savella
- ☐Cymbalta
- ☐Effexor (Venlafaxine)

OTHER
- ☐Topamax (topirimate)
- ☐Tegretol (Carbamazepine)
- ☐Trileptal
- ☐Neurontin
- ☐Dilantin
- ☐Depakote
- ☐Lyrica

PAST MEDICAL HISTORY:

Have you had any of the following health problems (Please check all that apply)?

- ☐Hypertension
- ☐Heart Attack
- ☐Emphysema
- ☐Stroke
- ☐Depression
- ☐Coronary Artery Disease
- ☐Diabetes
- ☐Kidney Disease
- ☐Seizure or Epilepsy
- ☐Anxiety
- ☐Chest Pain
- ☐Asthma or Wheezing
- ☐Liver Disease
- ☐Bleeding Problem
- ☐Thyroid Disease
- ☐Arthritis (specify location) ____________________
- ☐Cancer (what type) ____________________
- ☐Other ____________________

PAST SURGICAL HISTORY:

DATE	TYPE OF SURGERY

CURRENT MEDICATIONS FOR PAIN:

NAME	DOSE	FREQUENCY

CURRENT MEDICATIONS (Other than above):

NAME	DOSE	FREQUENCY

ALLERGIES: Please list the names of medications to which you are allergic.

____

What type of reaction?____

I am allergic to contrast dye used for x ray? _______YES _______ NO

SOCIAL HISTORY:

EMPLOYMENT: Your current or most recent occupation:

☐Semi-skilled or Unskilled (i.e. Waitress, assembler)
☐Skilled trade or clerical (eg. Carpenter, electrician, truck driver, secretary)
☐Business executive or Managerial
☐Professional (eg. Lawyer, teacher, nurse, physician, psychologist)
☐Homemaker
☐Other: Please specify____

CURRENT EMPLOYMENT STATUS: Please check one:

☐Employed Full-time ☐Retired
☐Employed Part-time ☐Student
☐Unemployed ☐Homemaker

LEGAL ISSUES: Please indicate any of the following claims you have filed related to your pain problem:

☐Worker's Compensation
☐Personal Injury/ Liability
☐Social Security Disability Insurance
☐Other: please specify ____

SLEEP DISTURBANCE:

Do you have difficulty falling asleep? ☐Yes ☐ No
Do you have difficulty staying asleep? ☐Yes ☐ No
Are you ever awakened by pain? ☐Yes ☐No

FAMILY LIFE: Please specify living arrangements:

☐Living alone ☐Living with friends
☐Living with spouse/ partner ☐Living with other
☐Living with spouse/ partner and children ☐Living with children

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem including your current pain?
☐Yes ☐No

For what diagnosis were you treated and when? ____

Please list your current therapist: ____

SUBSTANCE ABUSE:

Have you ever been a smoker? ☐Yes-Current ☐Yes-In past ☐No-Never
If you smoke, how many packs per day? __________ Packs per day
For how many years did you smoke? __________ Years

Do you have a history of alcoholism? ☐Yes ☐No ☐Current Problem
Have you abused prescription analgesics? ☐Yes ☐No ☐Current Problem
Cocaine or intravenous substance abuse? ☐Yes ☐No ☐Current Problem

How many years has it been since you abused alcohol or drugs? __________Years

If you have a history of alcoholism, have you ever been enrolled in Alcoholics Anonymous?
☐Yes ☐No When? __________

If you have a history of substance abuse, have you ever been in a detoxification program?
☐Yes ☐No When? __________

FAMILY HISTORY: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

Condition: ______________________ Specific family member(s): ______________________

Condition: ______________________ Specific family member(s): ______________________

Condition: ______________________ Specific family member(s): ______________________

REVIEW OF SYSTEMS: Please check all items you feel apply to you:

☐Recent gain of weight:_________ pounds over weeks/months/years __________
☐Recent loss of weight: _________ pounds over weeks/months/years __________
☐Fever
☐Dizziness
☐Difficulty swallowing
☐Double or blurry vision
☐Nausea
☐Vomiting
☐Constipation
☐Diabetes
☐Genital pain
☐Chest pain
☐Heart palpitations
☐Shortness of Breath
☐Wheezing
☐Memory loss
☐Difficulty urinating

☐
☐ Loss of Consciousness
☐ Seizures
☐ Easy or excessive bruising
☐ Easy or excessive bleeding
☐ Rash Diarrhea
☐ Adrenal Disease
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Joint stiffness
☐ Decreased Range of Motion
☐ Pain in extremity (specify)______________________
☐ Swelling (specify)______________________

☐ Difficulty walking
☐ Muscle weakness

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