Personalized
PAIN AND SPINE CARE

PAIN QUESTIONNAIRE

Please complete this form before your first appointment. Your careful answers will help us better understand your pain problem, allowing us to design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Workman's Compensation Claims).

1 Referring Physician _____ Primary Care Physician *(if not same)* _____

2 _____ **2a** Age _____ **2b** Sex: ☐ M ☐ F
Last Name First M.I.

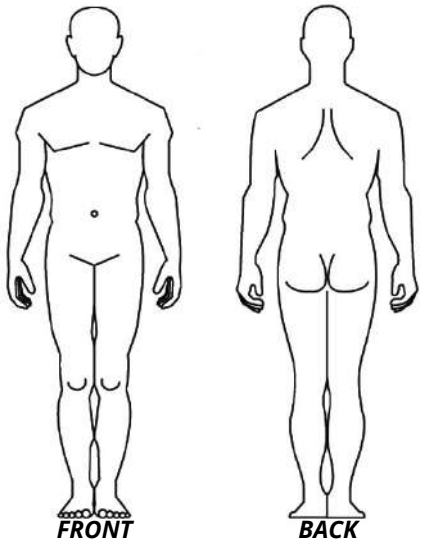
2c _____ **2d** _____
Medical Record Number Date of Birth

3 **ABOUT YOUR PAIN (Diagnosis)**
What is the main problem for which you are seeking treatment at the Pain Management Center?

_____
_____

PAIN LOCATION

Please mark the location(s) of your pain on the diagrams above with an **"X".**



4 **ONSET OF PAIN and DURATION**
Briefly describe when and how your current pain started?

_____
_____
_____
_____

_____
Last Name, First Name

NEW PATIENT FORM

5 TIMING OF PAIN

How often do you have your pain? *(please check one)*

- ☐ Constantly (100% of the time)
- ☐ Frequently (75% of the time)
- ☐ Intermittently (50% of the time)
- ☐ Occasionally (25% of the time)

6 PAIN QUALITY

How would you describe the pain? *(Choose as many as applicable)*

☐ Burning	☐ Sharp	☐ Cutting	☐ Throbbing
☐ Cramping	☐ Numbness	☐ Dull / Aching	☐ Pressure
☐ Pins & Needles	☐ Shooting	☐ Electric-like	☐ Other_____

7a PAIN INTENSITY

Select your current pain intensity with "0" representing no pain and "10" the most severe pain imaginable.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7b

Select your best pain score in the last 7 days.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7c

Select your worst pain score in the last 7 days.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8 a-c RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain? *(Please check one for each item)*

	8a Decreases	8b Increases	8c No Change
Lying Down.....	☐	☐	☐
Standing.....	☐	☐	☐
Sitting.....	☐	☐	☐
Walking	☐	☐	☐
Exercise (if applicable).....	☐	☐	☐
Medications.....	☐	☐	☐
Relaxation.....	☐	☐	☐
Thinking About Something Else.....	☐	☐	☐
Coughing/Sneezing.....	☐	☐	☐
Urination.....	☐	☐	☐
Bowel Movements	☐	☐	☐

_____
Last Name, First Name

NEW PATIENT FORM

9 **FUNCTIONAL LIMITATIONS**

During the past month, place a check mark next to the activities that you avoided because of pain.

- ☐ Going to work
- ☐ Performing Household Chores
- ☐ Doing Yard Work or Shopping
- ☐ Socializing With Friends
- ☐ Participating In Recreation
- ☐ Having Sexual Relationships
- ☐ Physically Exercising
- ☐ Driving
- ☐ Caring For Self

10a How many blocks can you walk before having to stop secondary to pain?

_____ blocks

10b How many minutes or hours can you sit before having to get up and move about?

_____ minutes _____ hours

10c How many minutes or hours can you stand before you have to sit down?

_____ minutes _____ hours

10d How often during the day do you lie down because of pain?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Constantly

10e What are your goals for treatment?

1. _____
2. _____
3. _____

11a **CURRENT MEDICATIONS**

Please list your current medications with dosage and frequency or attach a separate list.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

11b **PREVIOUS PAIN MEDICATIONS**

Please list any previously taken pain medications that you stopped taking and the reason for stopping.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

NEW PATIENT FORM

12 **ALLERGIES**

Please indicate the names of any medications that you are allergic to and what happened to you when you took it/them.

_____

_____

13a-c **PAIN TREATMENTS**

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date *(approx.)*	13a Excellent Relief	13b Moderate Relief	13c No Relief
☐ Traction	_____	☐	☐	☐
☐ Surgery	_____	☐	☐	☐
☐ Hypnosis	_____	☐	☐	☐
☐ Acupuncture	_____	☐	☐	☐
☐ Nerve Block / Injection	_____	☐	☐	☐
☐ TENS	_____	☐	☐	☐
☐ Physical Therapy	_____	☐	☐	☐
☐ Exercise	_____	☐	☐	☐
☐ Heat Treatment	_____	☐	☐	☐
☐ Biofeedback	_____	☐	☐	☐
☐ Psychotherapy	_____	☐	☐	☐
☐ Chiropractic	_____	☐	☐	☐
☐ Regenerative Medicine	_____	☐	☐	☐
☐ Other_____	_____	☐	☐	☐

14 **PREVIOUS DIAGNOSTIC STUDIES**

Please include approximate date and results, if known.

MRI _____

CT _____

X-Rays _____

EMG _____

_____

Last Name, First Name

NEW PATIENT FORM

15 **ROS: Please check any of the following signs or symptoms that you feel are applicable to you now.**

Dictate Only **"YES"** Answers
Yes

- ☐ Fever or Chills
- ☐ Unplanned Weight Loss
- ☐ Double or Blurred Vision
- ☐ Hearing Loss
- ☐ Difficulty Swallowing
- ☐ Bleeding Gums
- ☐ Low Platelet Count
- ☐ Heat ☐ or Cold ☐ Intolerance *(select which one)*
- ☐ Thyroid Problems
- ☐ Skin Rash
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Palpitations *(awareness of fast heartbeat)*
- ☐ Chest Pain
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Nausea / Vomiting
- ☐ Diarrhea
- ☐ Sexual Dysfunction
- ☐ Urinary Retention or Difficulty Urinating
- ☐ Back Pain
- ☐ Joint Pain *(knee, elbow, etc...)*
- ☐ Muscle Pain
- ☐ Loss of consciousness or Blackouts
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Seizures
- ☐ Trouble Walking
- ☐ Dizziness
- ☐ Drowsiness or Excessive Fatigue
- ☐ Difficulty Falling or Remaining Asleep
- ☐ Loss of Interest in Hobbies or Other Activities
- ☐ Difficulty Concentrating
- ☐ Feelings of Guilt
- ☐ Feeling Depressed

Office use Only

- ☐ Constitutional
- ☐ Eyes
- ☐ ENT
- ☐ Hematologic/Lymph
- ☐ Endocrine
- ☐ Integumentary
- ☐ Resp
- ☐ Cor
- ☐ GI
- ☐ GU
- ☐ Musculoskeletal
- ☐ Neuro
- ☐ Behav

16 **OTHER PAIN PROBLEMS**
Do you have other pain problems? What are they?

_____

NEW PATIENT FORM

17 PAST MEDICAL HISTORY

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

- ☐ Angina (Chest pain)
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Depression/Anxiety or Bipolar disorder
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Hepatitis (A, B, C)
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease / COPD
- ☐ Other (specify) _____
- ☐ Psychological
- ☐ Psychological / Psychiatric Problems
- ☐ Seizures or Epilepsy
- ☐ Stroke

Please explain any medical condition checked above and how long you have had them.

_____

_____

18 ALL SURGERIES

(approximate date and type of operations)

_____ _____

_____ _____

19 PSYCHOSOCIAL HISTORY – EDUCATION

Your highest educational level achieved:

- ☐ Graduate or Professional Training (obtained degree)
- ☐ College Graduate (obtained degree)
- ☐ Partial College Training
- ☐ High School Graduate
- ☐ GED or Trade-Technical School Graduate
- ☐ Partial High School (10th Grade through partial 12th Grade)
- ☐ Partial Junior High School (7th Grade through 9th Grade)
- ☐ Elementary School (6th Grade or Less)

20 LEGAL ISSUES

Please indicate any of the following claims you have filed related to your pain problem.

- ☐ Worker's Compensation
- ☐ Personal Injury / Liability (unrelated to work)
- ☐ Social Security Disability (unrelated to work)
- ☐ Other Insurance (explain _____)
- ☐ None

NEW PATIENT FORM

21 PSYCHOLOGICAL TREATMENT

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

If yes, when and for what problem? _____

Have you ever considered suicide? ☐ Yes ☐ No

If yes, was there an attempt? ☐ Yes ☐ No

If yes, when _____

22 SUBSTANCE ABUSE

Are you suffering from or do you have a history of alcoholism?	☐ Yes	☐ No
Heroin Abuse?	☐ Yes	☐ No
Cocaine or Amphetamine Abuse?	☐ Yes	☐ No
Prescription Pain Medicine Abuse?	☐ Yes	☐ No
Marijuana Use or Abuse?	☐ Yes	☐ No
Have you ever been in a detoxification program for drug abuse?	☐ Yes	☐ No
Alcoholics Anonymous?	☐ Yes	☐ No
Narcotics Anonymous?	☐ Yes	☐ No
Do you or did you ever smoke cigarettes or use tobacco?	☐ Yes	☐ No
How many years have you or did you smoke?	_____	
How many packs per day do you or did you smoke?	_____	
Have you quite using tobacco and if so how long ago?	_____	

23a-d EMPLOYMENT

23a Current Employment Status *(please check all that apply)*

- ☐ Employed Full-Time
- ☐ Employed Part-Time
- ☐ Temporary Disabled
- ☐ Permanently Disabled
- ☐ Unemployed
- ☐ Homemaker
- ☐ Retired
- ☐ Student
- ☐ Unemployed Because of Pain

23b ☐ Your employment status HAS ☐ HAS NOT ☐ *(select one)* been affected by the present pain condition?

23c If unemployed, how long have you been off work?_____ months _____ years

23d Your current or former occupation (s): _____

NEW PATIENT FORM

24 FAMILY LIFE

Living arrangements: " I am currently……."

- ☐ Living Alone
- ☐ Living With Friends
- ☐ Living With Children
- ☐ Living With Spouse / Partner
- ☐ Living With Spouse / Partner and Children

25 FAMILY HISTORY

Do you have members of your family who have had migraine headaches?	☐ Yes	☐ No
Back Pain?	☐ Yes	☐ No
Committed Suicide?	☐ Yes	☐ No
Had Psychiatric Illnesses?	☐ Yes	☐ No

I hereby authorize Personalized Pain and Spine Care to release the reports of my evaluations and treatments, including psychological, to my physicians and other relevant persons listed below:

Signature: _____

Date: _____

Printed Name: _____

Physicians/Providers/Attorney/Case Manager/ Other	Address	Phone Fax