



# Pain Questionnaire

Phone (217) 464-PAIN (7246)

Fax (217) 464-1672

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Soc. Sec.: \_\_\_\_\_

Sex:  M  F

Employer/Occupation: \_\_\_\_\_

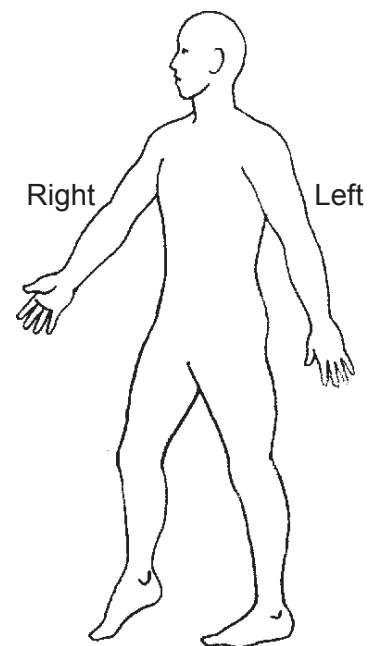
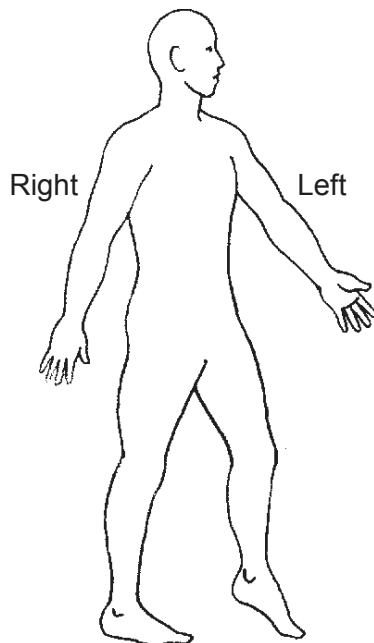
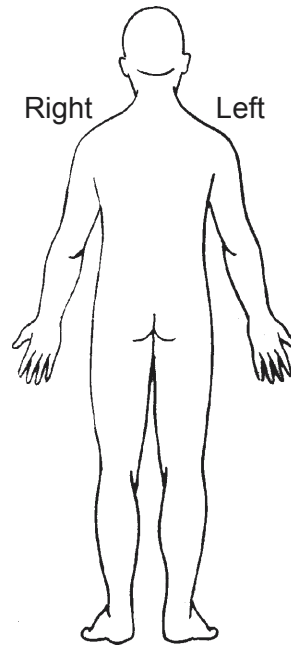
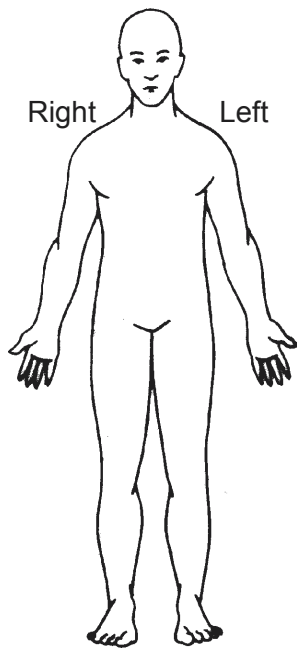
Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Marital Status:  M  S  D  W

Primary/Family Physician: \_\_\_\_\_

Please mark the painful sites in your body on the diagram below:



## Pain History:

1. Where is your pain? (Please list most severe first):

- A. \_\_\_\_\_  
B. \_\_\_\_\_  
C. \_\_\_\_\_

2. What does your pain feel like?

- Burning                       Shooting                       Throbbing                       Crushing  
 Dull & achy                       Electrical                       Sharp                       Pulling  
 Toothache like                       Stabbing                       Other (describe): \_\_\_\_\_

3. Does your pain travel anywhere? If YES, where?

\_\_\_\_\_  
\_\_\_\_\_

4. Please indicate the amount of pain you have by placing an 'X' on the scale below, '0' being no pain at all and '10' being the most severe pain ever experienced.

Today:                      0            1            2            3            4            5            6            7            9            10  
Average day:            0            1            2            3            4            5            6            7            9            10

5. When did your pain begin (date): \_\_\_\_\_

6. How did the pain start? / What do you think caused it?

\_\_\_\_\_

7. Please describe the course of your pain during the day:

- Constant             Intermittent             Constant but varies             Hour to hour             Day-to-day

8. What makes your pain feel worse?

- Sitting             Standing             Walking             Lifting             Bending  
 Lying flat             Driving             Climbing stairs             Straining             Laughing  
 Coughing             Sneezing             Sex             Other: \_\_\_\_\_

9. What makes your pain feel better?

- Medication             Massage             Lying down             Standing             Walking  
 Sitting             Heat             Ice             Applying pressure  
 Other: \_\_\_\_\_

10. Are there other symptoms associated with your pain or that you have from other conditions?

- Weakness             Sweating             Diarrhea             Nausea             Dizziness  
 Shortness of breath             Fever             Chills             Night sweats             Chronic fatigue  
 Ringing in the ears             Constipation             Headaches             Bleeding or bruising tendencies  
 Chest pain             Fainting             Falling             Dropping things  
 Irregular heart beats             Other: \_\_\_\_\_

11. Have you had any of the following over the painful area?

- Swelling             Redness             Blue discoloration             Blanching of the skin

12. Is your sleep disturbed due to pain?     Yes     No    If YES, please answer the following:

- I usually go to bed at \_\_\_\_\_ o'clock.
- I first wake up at \_\_\_\_\_ o'clock.
- I usually get about \_\_\_\_\_ hours of sleep at a time.
- Usual percentages of time I get disturbed sleep only due to pain: \_\_\_\_\_

13. Have you gone to the ER for this pain?     Yes     No

- How often does this happen \_\_\_\_\_
- What treatment is given \_\_\_\_\_

**Medical History:**

1. Height:\_\_\_\_\_ Weight:\_\_\_\_\_

2. Allergies (please list **ALL** known allergies AND the type of reaction):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recent illness:\_\_\_\_\_

3. Cardiovascular system:

- None                       High blood pressure       Chest pain       Heart attack       Aneurysm
- Circulation problems     Irregular heart rate       Stroke/CVA       Mitral valve prolapse
- Pacemaker/AID           Stent                               Other:\_\_\_\_\_

4. Nervous System:

- None     Neuropathy  Seizures     Meningitis     Other\_\_\_\_\_

5. Respiratory System:

- None     Asthma       Pneumonia  Emphysema
- Smoking - How much?\_\_\_\_\_ How long?\_\_\_\_\_       Other\_\_\_\_\_

6. Gastrointestinal System:

- None     Ulcers       Hiatal hernia       Hernia       Nausea/Vomiting/Diarrhea

7. Metabolic Diseases:

- None     Diabetes     Thyroid       Liver disease       Bleeding problem
- Alcohol/Drugs - How much?\_\_\_\_\_ How long?\_\_\_\_\_
- Do you use any recreational drugs:     Yes     No

\_\_\_\_\_

8. Genitourinary System:

- None     Pregnancy  Kidney Failure/Problems     Other\_\_\_\_\_

9. Musculoskeletal System:

- None     Arthritis       Muscle aches/spasms       Congenital spine problems

10. Infectious Diseases:

- None     Hepatitis     AIDS/HIV+       Other\_\_\_\_\_

11. Psychological problems:

- None     Anxiety       Depression       Personality disorder
- Other\_\_\_\_\_

12. Cancer (site)\_\_\_\_\_

13. Other (Abuse, ADD, Bipolar)\_\_\_\_\_

**Surgical History:**

List those surgeries NOT for this problem (with dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:**

Name and dosage (can bring list)

Pain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Herbal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you pay for medications? \_\_\_\_\_

**Family, Work, Social History:**

Does this problem or related problems run in the family?  Yes  No

Explain \_\_\_\_\_  
\_\_\_\_\_

Employer/Occupation: \_\_\_\_\_  
\_\_\_\_\_

How has this problem affected your job? \_\_\_\_\_  
\_\_\_\_\_

How has this problem affected you socially? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Can you still perform activities of daily living? If NO , what activities are affected: \_\_\_\_\_  
\_\_\_\_\_

Is nutrition affected by pain or medications? \_\_\_\_\_

**Past Treatments for your Pain**

Have you had any surgeries for your pain?  Yes  No

If YES, please list all the surgeries for pain (with dates by physician): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any "Pain Blocks"?  Yes  No

If YES, please list all the procedures (injections, etc.) below with dates if known.

_____	_____
_____	_____
_____	_____
_____	_____

Have you had any physical therapy?  Yes  No If YES, how long? \_\_\_\_\_

When was the last time you had physical therapy? \_\_\_\_\_

Please list all the treatments that have helped you in the past:

_____
_____
_____
_____

**Past Diagnostic Studies:**

Please check all tests you have had for this pain (**please write the dates if known, & where done**):

- |                                          |                                        |
|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> X-rays:_____    | <input type="checkbox"/> MRI:_____     |
| <input type="checkbox"/> Myelogram:_____ | <input type="checkbox"/> CT Scan:_____ |
| <input type="checkbox"/> Bone Scan:_____ | <input type="checkbox"/> EMG:_____     |
| <input type="checkbox"/> Other:_____     |                                        |

**Pharmacy:**

Pharmacy\_\_\_\_\_

Phone #:\_\_\_\_\_

**Other specialist involved in your care**

Dentist\_\_\_\_\_

OB/GYN\_\_\_\_\_

Other\_\_\_\_\_