

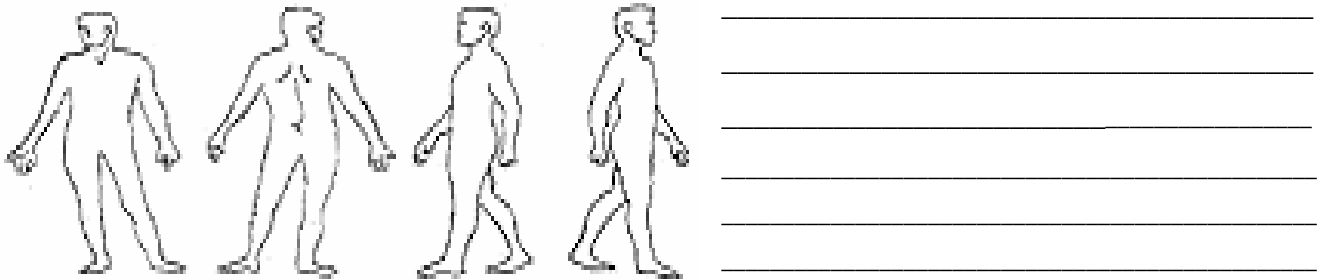
NEW PATIENT PAIN QUESTIONNAIRE

Doctors
Notes

Today's Date _____	Last Name _____	First Name _____	Middle _____
Age _____	Height _____	Weight _____	Date of Last Menstrual Period _____

1. If the pain you have is related to an accident what is the date of accident? _____ () **Not related to accident**
2. Present pain is: headaches, neck, mid back, low back, right//left arm, right/left leg, other _____

Label the areas that hurt with an X on diagram below. **If pain is from an accident, briefly describe how accident occurred here**



3. **ANY OLD ACCIDENTS BEFORE?** () **NO- if no, go to question #4** If yes, List **PREVIOUS** accidents below

What year	Accident Type (car, work, slip/fall)	Part(s) of body injured?	Are you still with pain from old accident?
1st: _____	_____	_____	yes no
2nd _____	_____	_____	yes no

4. Check the word(s) that best describe your present pain?

- | | | | | |
|-----------------------------------|-----------------------------------|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Pressure | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stinging | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Cutting | <input type="checkbox"/> Burning | <input type="checkbox"/> Heavy | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shooting | <input type="checkbox"/> Tender | <input type="checkbox"/> Aching | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Sore | <input type="checkbox"/> Pulling | <input type="checkbox"/> Other (Specify) _____ | | |

5. What is your pain level at its best? 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worse pain ever)

What is your pain level at its worst? 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worse pain ever)

Where is the pain worse? _____ Neck _____ Mid Back _____ Low Back _____ Other _____

6. How often does the moderate or severe pain occur?

Continuously (nonstop) Several times a day Once or twice a day other _____

7. When is your pain Better/worse? **Same all the time.** Otherwise, circle below

Morning - Better/worse Day - Better/worse Evening - Better/worse Sleep - Better/worse

8. What position(s) makes your pain Better/worse? **same with all positions.** Otherwise, circle below

Sitting - Better/worse Standing - Better/worse Lying - Better/worse

9. Are there any of these activities that you **HAVE DIFFICULTY DOING** because of your pain? () **NO**

Walk Drive Swim Dance Grocery Shop Climb Stairs Dress/Undress Sleep Work
 Sex Jog Family Activities Play/ Recreation

10. Do you have trouble falling asleep? () No () Yes, Number times wake up at night due to pain? _____

11. Do you use? ___Cane ___Walker ___Wheelchair ___Brace ___Crutches ___Orthopedic Shoes

12. Circle the word(s) that describe(s) how your pain makes you feel:

Angry Tense Depressed Irritable Scared Sad nervous Restless Other _____

13. Do you have any problems with: **Bowel** action? () Yes () No **Bladder** action? () Yes () No

If yes, what is the problem _____

14. Occupation () Student (describe job) _____

() **Not working** - how long have you been off work? _____

() Currently working - Full time/Part time - Full duty/Light duty - Any climbing involved - yes/no or heavy lifting - yes/no

15. Do you have any **Legal Action** pending related to your pain or health problem? () Yes () No

16. What treatments have you tried for your pain? (Leave blank if **NOT** tried):

___ Traction	Helped ___a lot ___some ___no	___ Pain Relievers	Helped ___a lot ___some ___no
___ Surgery	Helped ___a lot ___some ___no	___ Tranquillizers	Helped ___a lot ___some ___no
___ Nerve Blocks	Helped ___a lot ___some ___no	___ Muscle Injection	Helped ___a lot ___some ___no
___ Braces or Cast	Helped ___a lot ___some ___no	___ Acupuncture	Helped ___a lot ___some ___no
___ Chiropractic	Helped ___a lot ___some ___no	___ Massage	Helped ___a lot ___some ___no
___ Physical Therapy	Helped ___a lot ___some ___no	___ Psychotherapy	Helped ___a lot ___some ___no
___ TENS	Helped ___a lot ___some ___no	___ Biofeedback	Helped ___a lot ___some ___no
___ Relaxation Training	Helped ___a lot ___some ___no	___ Hypnosis	Helped ___a lot ___some ___no
___ Home Exercise	Helped ___a lot ___some ___no	___ Homeopathy	Helped ___a lot ___some ___no

Other _____

17. What test(s) have you had for your pain:

_____ X-Rays _____ MRI _____ Bone Scan _____ CAT scan _____ EMG/ Nerve Conduction Study

18. **ALLERGIES:** () NONE LIST: _____

19. **MEDICATIONS:** (List **ALL**, whether prescription or Over-The-Counter)

Do you take **BLOOD THINNERS**? ___None___ Coumadin___ Plavix (Clopidogrel) ___ Trental (Pentoxifylline)

Please list any **MEDICATIONS** you are **NOW TAKING** (include **over the counter** medicines):

Drug	Strength	# of pills per day	Side Effects	If for pain, effect on pain
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no
_____	_____	_____	_____	Helped ___a lot ___some ___no

Please list all MEDICATIONS you have tried in **THE PAST FOR YOUR PAIN:**

Drug	Maximum Dose Used	Why Stopped/Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. **HEALTH HISTORY** (Check if you have a history – past or present - of any of these health conditions):

Heart trouble _____ None

- _____ Heart Disease
- _____ Irregular Heart Beat
- _____ Heart Attack
- _____ Angina
- _____ High Blood Pressure
- _____ Pacemaker
- _____ Congestive Heart Failure

Lung Problem _____ None

- _____ Asthma
- _____ Emphysema
- _____ Bronchitis
- _____ Pneumonia
- _____ Sinus Infection
- _____ Pulmonary Embolus (blood clot on lungs)
- _____ TB

Neurological problems _____ None

- _____ Headaches (in the past)
- _____ Stroke
- _____ TIA'S (little, brief strokes)
- _____ Myasthenia Gravis
- _____ Multiple Sclerosis
- _____ Head Injury in past. When _____
- _____ Seizures _____ Shingles

Musculoskeletal problems _____ None

- _____ Arthritis
- _____ Fibromyalgia
- _____ Phlebitis/DVT
- _____ Fractures - Which part of body?

- _____ Gout
- _____ Other _____

Skin problem(s) _____

Digestive problems _____ None

- _____ Ulcers
- _____ Liver/Hepatitis ___A ___B ___C ___other _____
- _____ Colitis
- _____ Crohn's
- _____ Tic's (Diverticulosis)
- _____ Pancreatitis
- _____ Gall Bladder (Infection = Cholecystitis,
Stones = Cholelithiasis)

Endocrine/Immune problem _____ None

- _____ Diabetes
- _____ Hypo~~th~~thyroid (low functioning)
- _____ Hyperthyroid (over functioning)
- _____ Parathyroid Glands _____
- _____ Adrenal Gland _____
- _____ Kidney __ Infection __Stones __ Failure
- _____ Lupus
- _____ HIV/AIDS _____ Herpes

Have you ever had cancer _____None If yes, which part of body?

- _____ Brain
- _____ Breast
- _____ Lung
- _____ Colon
- _____ Prostate
- _____ Lymphoma
- _____ Leukemia
- _____ Myeloma _____ Skin/Other: _____

Cancer Treatment _____ None

- _____ Surgery
- _____ Chemotherapy
- _____ Radiation
- _____ Hormones
- Other: _____

Have you ever been diagnosed with? _____ None

- _____ Depression _____ Bipolar (Manic/Depressive) _____ Paranoid
- _____ Anxiety _____ OCD (Obsessive Compulsive Disorder) _____ Schizophrenia
- _____ Panic Attacks _____ Attention Deficit Disorder
- _____ Suicide behavior () No () Yes, When? _____

21. LIST SURGERY/OPERATIONS _____ Never had an operation (Please put DATES as best you can)

22. **SOCIAL HISTORY:** Do you smoke? () No () Yes, # of Packs a day? _____

Alcohol use () No () Yes _____ social _____ rarely _____ occasional _____ moderate _____ heavy

Coffee () No () Yes, about how many cups per day? _____

Do you use Recreational/Illegal Drugs () No () Yes, which? _____

Have you ever been treated for any **addiction** () No If yes, what substance(s) _____ When _____

____ Married ____ Divorced ____ Widow ____ Single ____ Retired ____ Disabled ____ Other _____

of Children _____ (ages: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____)

23. **FAMILY HISTORY:** any direct relatives (Mother, Father, Brother, Sister) with the following disorders?

Diabetes: () No () Yes, who? _____

High Blood Pressure: () No () Yes, who? _____

Heart Disease: () No () Yes, who? _____

Early Onset Arthritis (**before age 30**): () No () Yes, who? _____

Cancer: () No () Yes, who? _____

24. **Review of Systems (check any that you are now experiencing, or mark NONE)**

NONE

- GENERAL () () Weight Loss () Loss of Appetite () Fever () Cancer
- Eyes () () Glasses/Contacts () Double Vision () Spots in Vision () Cataract
- ENT () () Hearing Loss () Hoarseness () Ringing In Ears
- Heart () () Chest Pain () Heart Attack () Blood Blots
- Lung () () Wheezing () Cough () Congestion () Short of Breath
- Urinary () () trouble passing urine () trouble holding urine () Bed Wetting () Pain with Urination () Blood in Urine
- Skin () () Skin Ulcers () Rash () Itching () Lumps
- Nervous Sys () () Muscle Spasm () Memory Loss () Dizziness () Balance Problem () Headaches
- Psych () () the blues/Depression () Nervousness () Sleep Disorder (Sleep Apnea)
- HEM () () unexplained bleeding () Easy Bruising () Anemia (low blood count)

25. Are you pregnant? _____ N/A _____ yes _____ no _____ not sure

Patient Signature: _____ Date: _____