The Physicians Pain Center

Initial Questionnaire
Please answer **all** questions as this helps us tailor a treatment plan for you

Name: _____ Date of Birth _____ Age ____ Date: _____

Referring Physician: _____ Primary Care Physician _____

Current Problem: When did it start? _____

How did it start? Gradual / Sudden / No Obvious Reason / Other _____

Motor-Vehicle Accident? No Yes When? _____ Workers' Compensation? No Yes When? _____

Other? _____

Describe Your Pain Below (use back of paper if needed):

Where does it start? _____ Does it go anywhere? _____

_____

_____

_____

_____

Are you psychologically affected by the pain? Mildly / Moderately / Severely

On a scale of 0 to 10 (0 being pain and 10 being the worst pain you ever experienced), what is

Your pain now? _____ What is your average pain score? _____

What is your pain with medications? _____ Without medications? _____

Which medications help the most? _____

Is the pain worsening? YES NO

Please circle **ONE** word in each group that describes your pain if applicable:

1. Flickering Quivering Pulsing Throbbing Beating Pounding	2.Jumping Flashing Shooting	3. Pricking Boring Drilling Stabbing Lancinating	4.Sharp Cutting Lacerating Crushing	5.Pinching Pressing Gnawing	6.Tugging Pulling Wrenching
7. Hot Burning Scalding Searing	8.Tingling Itchy Smarting Stinging	9.Dull Sore Hurting Aching Heavy	10.Tender Taut Rasping Splitting	11.Tiring Exhausting	12.Sickening Suffocating
13. Fearful Frightful Terrifying	14.Punishing Grueling Cruel Vicious Killing	15.Wretched Blinding	16.Annoying Troublesome Miserable Intense Unbearable	17.Spreading Radiating Penetrating Piercing	18.Tight Numb Squeezing Tearing Drawing
19. Cool Cold Freezing	20.Nagging Nauseating Agonizing Dreadful Torturing	21.Brief Momentary Transient	22.Rhythmic Periodic Intermittent	23.Continuous Steady Constant	

Name: _____

What activities make the pain better? _____ Worse? _____

How frequently do you have the pain? _____

When is the pain the best? _____ Worse? _____

What would you like to do but cannot due to the pain? _____

What can you still do (with the pain)? _____

How far can you walk? _____ How much can you lift? _____

Do you sleep well at night? Yes No Why? _____

Do you use a cane, brace, wheelchair or other device because of this problem? _____

What kind of treatment have you had for this pain? _____

Did/Does the treatment work? _____ For how Long? _____ How much improvement? _____

Circle the tests you have had for this problem and list the date and location of the test(s):

X-RAYS Date _____ Where _____

MRI Date _____ Where _____

EMG/NCV Date _____ Where _____

Other Date _____ Where _____

Current Medications: ***(Please include all medications including over-the-counter medications, vitamins, or other supplements)***

Medication	Dosage	Frequency	Prescribed by

Past Pain Medications and the reason you discontinued them:

_____ Why stopped? _____

_____ Why stopped? _____

_____ Why stopped? _____

_____ Why stopped? _____

Name: _____

Past Medical History: (Please Circle and Describe)

Heart Disease	Y N _____	Reflux	Y N _____
Hypertension	Y N _____	Thyroid	Y N _____
Heart Attack	Y N _____	Diabetes	Y N _____
Lung Disease	Y N _____	Glaucoma	Y N _____
Asthma	Y N _____	Neuropathy	Y N _____
COPD	Y N _____	HIV	Y N _____
Emphysema	Y N _____	Blood problems	Y N _____
Liver Disease	Y N _____	Rheumatoid Arthritis	Y N _____
Hepatitis	Y N _____	Osteoporosis	Y N _____
Kidney Disease	Y N _____	DJD	Y N _____
Urinary Problems	Y N _____	Psychiatric problems	Y N _____
Sexual Dysfunction	Y N _____	Depression	Y N _____
Cancer	Y N _____	Anxiety	Y N _____
Seizures	Y N _____	Fibromyalgia	Y N _____
Stroke	Y N _____	Chronic Fatigue	Y N _____
Stomach problems	Y N _____	Other	_____
Ulcers	Y N _____		

Have you had a Pneumonia Vaccination: Y N if so when (year) : _____

Have you had a bone density Study: Y N if yes when: _____ **where:** _____

Past Surgical History:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Drug Allergies: ( ) NKDA

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Please describe and give dates of past accidents (motor-vehicle, work-related or other):

Accident _____ Date _____

Accident _____ Date _____

Accident _____ Date _____

Are you receiving Compensation? Y N What _____

Are you involved in a lawsuit? Y N What _____

Are you considering a lawsuit? Y N What _____

Social History:

Marital Status: (Circle One) Single Married Divorced Living with someone

Number of children with ages: _____

Highest level of education: _____ Degree _____

What is your current occupation? _____ Past Occupation? _____

Are you working now? _____ Do you enjoy work? _____

Do you smoke? Y N How much? _____ How long? _____

Did you previously smoke? Y N How much? _____How long? _____

Do you drink alcohol? Y N How much? _____ What? _____

Do you smoke marijuana? Y N How much? _____

Do you use cocaine? Y N How much? _____

Do you use crack? Y N How much? _____

Do you use intravenous drugs? Y N How much? _____

Do you have a history of dependency on medications? Y N What? _____ When?_____

Have you ever made a suicide attempt? Y N _____

Have you ever been subjected to abuse? Y N _____

Family Medical History:

Mother: History: _____ _____

Alive? YES NO Age _____, Deceased? YES NO Age: _____

Father: History:_____ _____

Alive? YES NO Age: _____, Deceased? YES NO Age: _____

Sister(s): _____ _____

Alive? YES NO Age: _____, Deceased? YES NO Age: _____

Brother(s): _____ _____

Alive? YES NO Age: _____, Deceased? YES NO Age: _____

Other Comments: _____

_____

_____

_____

_____

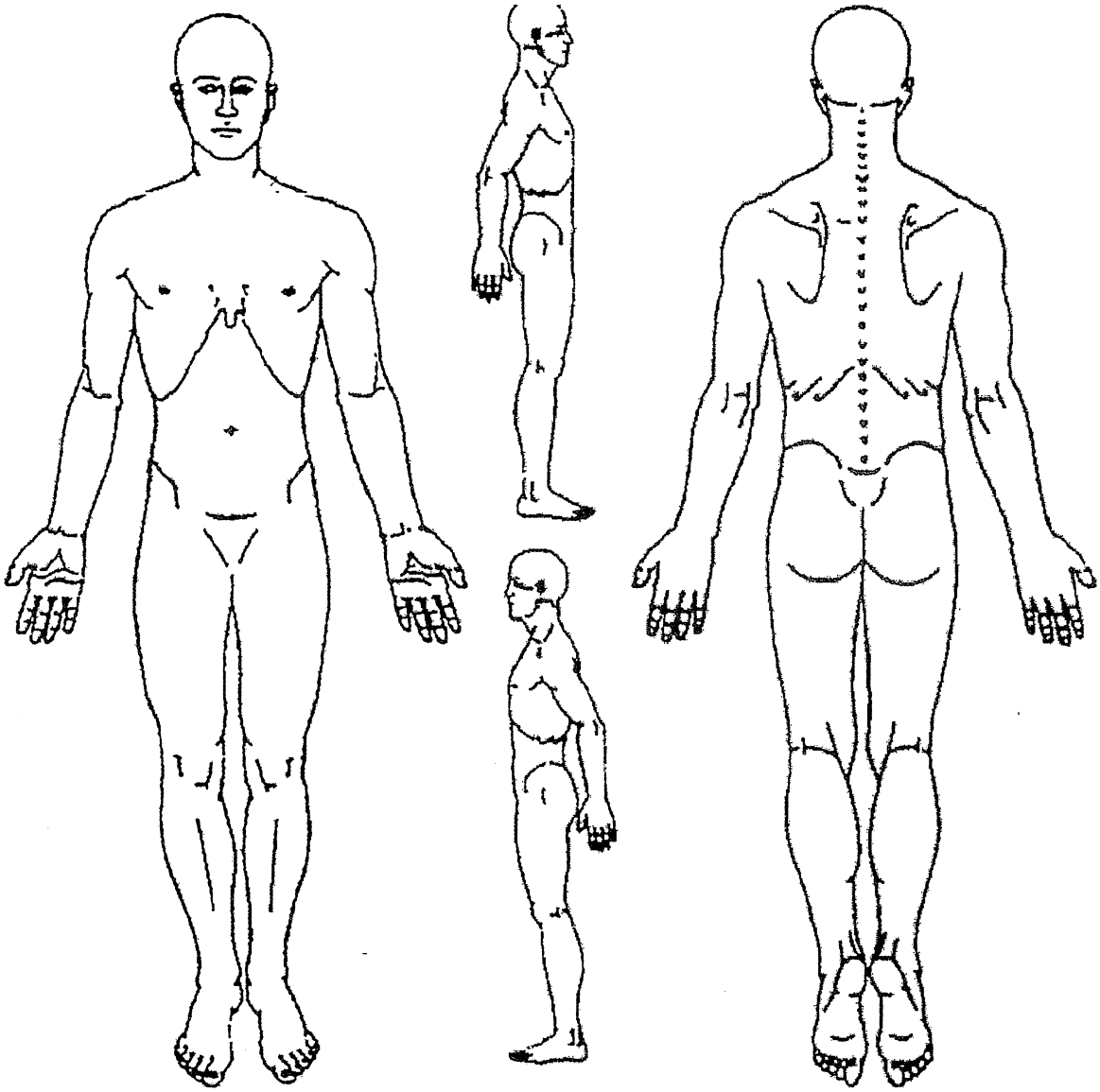
_____ _____ _____

Patient's Signature Print Name Date

_____ _____ _____

Signature of Person completing this form, (If other than the patient) Print Name Date

NAME: _____



Please indicate on this diagram where your pain is located by shading in the painful area(s).