

## Comprehensive Pain Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

**PAIN COMPLAINT:** \_\_\_\_\_

**WHEN/WHERE/HOW DID THE PROBLEM START:** \_\_\_\_\_

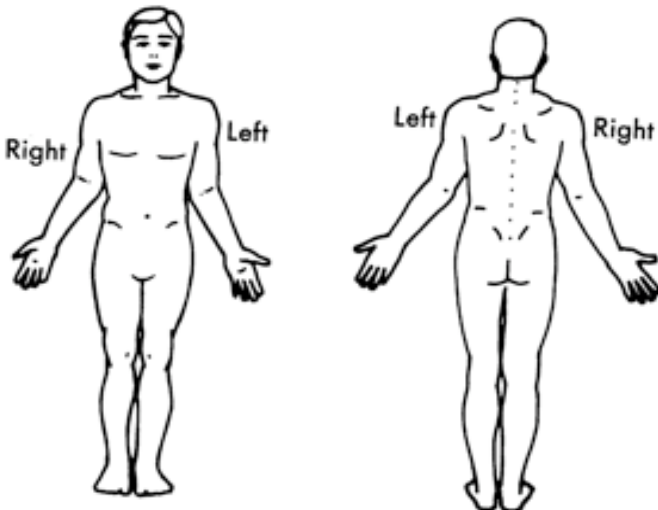
\_\_\_\_\_

\_\_\_\_\_

- When did you first see a physician for this condition? \_\_\_\_\_
- Have you seen Pain Management Specialist before? \_\_\_\_\_
- Which physicians have you seen for your current condition?  
 Primary Care Physician \_\_\_\_\_ Neurosurgeon \_\_\_\_\_  
 Neurologist \_\_\_\_\_ Physiatrist \_\_\_\_\_  
 Orthopedic surgeon \_\_\_\_\_ Other \_\_\_\_\_

- What diagnostic studies have you had?  
 MRI:  
 a. Back Date: \_\_\_\_\_  
 b. Neck Date: \_\_\_\_\_  
 CT scan:  
 a. Back Date: \_\_\_\_\_  
 b. Neck Date: \_\_\_\_\_  
 EMG Date: \_\_\_\_\_  
 X-rays Date: \_\_\_\_\_  
 Other \_\_\_\_\_ Date: \_\_\_\_\_

- Where **exactly** is your pain located? \_\_\_\_\_



**(0-10 scale where 0 is no pain and a 10 is the worst possible pain)**

I would rate my pain today a \_\_\_\_/10

I would rate my **worst** pain a \_\_\_\_/10.

I would rate my pain when **under control** as a \_\_\_\_/10.

I could **accept** or live with a level of pain at a \_\_\_\_/10.

- Describe your pain (**circle all that apply**):

Aching	Sharp/ stabbing
Burning	Soreness
Dull	Tingling
Pins and needles	Throbbing
Shooting	Other _____

- Have your symptoms been:

Worsening  
Unchanged  
Improving

- What makes your pain **INCREASE**?

Morning hours	Standing	Exercise
Evening hours	Stairs	Sitting
Cold	Walking	
Heat	Weather changes	
Other _____		

- What makes the pain **DECREASE**?

Rest	Prescription medication
Cold	Non prescription medication
Heat	Sitting
Exercise/ PT	Standing
Walking	Leaning over a shopping cart/ desk
Massage	Other _____

- How long can you:

Sit \_\_\_\_\_  
Stand \_\_\_\_\_  
Walk \_\_\_\_\_

- How far can you walk without discomfort \_\_\_\_\_ city blocks?

- How does the pain affect your work? \_\_\_\_\_

- Is the pain present: **Check One**

Constantly (76%-100% of the time) \_\_\_\_\_  
Frequently (51%-75% of the time) \_\_\_\_\_  
Occasionally (26%-50% of the time) \_\_\_\_\_  
Intermittently (25% of the time) \_\_\_\_\_

- Does the pain radiate to another area? \_\_\_\_\_

- Does the pain or symptoms cause a loss of bowel or bladder control? \_\_\_\_\_

- Is your sleep affected due to pain? \_\_\_\_\_

- Is sexual function affected? \_\_\_\_\_

**PAST MEDICAL HISTORY:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any Valve disease that requires antibiotic therapy before a procedure? Yes No**

**PAST SURGICAL HISTORY:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAIN MEDICATIONS TRIED:** \_\_\_\_\_

**REVIEW OF SYSTEMS (to be completed by Practitioner)**

**Constitutional** \_\_\_\_\_ **Eyes:** \_\_\_\_\_ **ENT:** \_\_\_\_\_ **Endo:** \_\_\_\_\_

**Resp:** \_\_\_\_\_ **Cardiac:** \_\_\_\_\_ **GI:** \_\_\_\_\_ **GU:** \_\_\_\_\_

**Neuro:** \_\_\_\_\_ **Musc:** \_\_\_\_\_ **Skin:** \_\_\_\_\_ **Psych:** \_\_\_\_\_

**Hem/Lymph:** \_\_\_\_\_ **Allergy/Immuno:** \_\_\_\_\_ **GYN/Breasts:** \_\_\_\_\_

**FAMILY HISTORY:** \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

**Alcohol use:** How much do you consume \_\_\_\_\_/Week?

**Tobacco use:** Do you smoke? No \_\_\_\_\_ Yes: \_\_\_\_\_/packs per day

**Recreational drug use:** \_\_\_\_\_

**Marital status:** Single Married Separated Divorced Other \_\_\_\_\_

**Highest Education:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Disability:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Litigation?** \_\_\_\_\_

(Lawyer contact information): ( ) \_\_\_\_\_