

**CARDINAL PAIN CENTER**  
**Pain Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS/COMPLAINT**

1. What problem are you here for today? \_\_\_\_\_

2. Date of onset (first episode) \_\_\_\_\_ Work-related: Yes \_\_\_ No \_\_\_

3. Explain how the pain started: \_\_\_\_\_

Rate the pain today from 1 to 10 with 10 being the greatest pain \_\_\_\_\_.

Rate the pain on a good day \_\_\_\_\_ Rate the pain on a bad day \_\_\_\_\_.

4. Describe the quality of pain (burning, aching, stabbing, throbbing, itching, tingling, numbness, pins and needles, weakness, etc): \_\_\_\_\_

\_\_\_\_\_ Radiation? Yes: \_\_\_ If yes, where to? \_\_\_\_\_ No: \_\_\_

5. How frequently do you have your pain? \_\_\_\_\_ Constant? \_\_\_\_\_ Intermittent? \_\_\_\_\_

How many hours during the day do you have it? \_\_\_\_\_

6. Does it wake you at night? \_\_\_\_\_

7. Is the pain worse in the morning, afternoon, evening, or at night? \_\_\_\_\_

8. How would you breakdown the components of your pain? (Total 100%)

Back \_\_\_\_\_% Neck \_\_\_\_\_% Right Leg \_\_\_\_\_% Right arm \_\_\_\_\_%

Left Leg \_\_\_\_\_% Left arm \_\_\_\_\_% Other \_\_\_\_\_%

9. What activities are affected most by the pain? \_\_\_\_\_

10. Has the pain interfered with (check one for each):

	<u>All the time</u>	<u>Sometimes</u>	<u>Never</u>
Appetite	_____	_____	_____
Sleep	_____	_____	_____
Marriage/Family Life	_____	_____	_____
Social activities	_____	_____	_____
Sexual activity	_____	_____	_____
Work	_____	_____	_____
Housework/Chores	_____	_____	_____
Hobbies/recreation	_____	_____	_____

11. Have you had any previous episodes of this pain? If yes, when? \_\_\_\_\_

12. Have you had prior surgery for this or similar problem? \_\_\_\_\_

13. Procedures and dates \_\_\_\_\_

14. Do you have any bowel or bladder dysfunction? If so, describe. \_\_\_\_\_

15. Please indicate previous treatment measures and results:

	<u>Not Tried</u>	<u>Very helpful</u>	<u>Partly Helpful</u>	<u>Worse</u>
Bed rest	_____	_____	_____	_____
Anti-inflammatory (aspirin, Advil)	_____	_____	_____	_____
Muscle relaxants	_____	_____	_____	_____
Narcotics (Vicodin, Darvocet, etc)	_____	_____	_____	_____
Heat	_____	_____	_____	_____
Ice	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
TENS (neurostimulator)	_____	_____	_____	_____
Pain Pump Implant	_____	_____	_____	_____
Daily exercises	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____

	<u>Not Tried</u>	<u>Very helpful</u>	<u>Partly Helpful</u>	<u>Worse</u>
Psychological counseling	_____	_____	_____	_____
Pain Clinic	_____	_____	_____	_____
Chiropractic treatment	_____	_____	_____	_____
Acupuncture/Acupressure	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Injections	_____	_____	_____	_____

- 16. Have you had plain x-rays? \_\_\_\_\_ If yes, when & where? \_\_\_\_\_
- 17. Have you had an MRI scan(s)? \_\_\_\_\_ If yes, when & where? \_\_\_\_\_
- 18. Have you had a myelogram? \_\_\_\_\_ If yes, when & where? \_\_\_\_\_
- 19. What other tests have you had for this? \_\_\_\_\_

**PAST MEDICAL HISTORY**

- 20. List current and past medical problems, including hospitalizations and dates. Example: High blood pressure, stroke, asthma, heart disease, liver disease, kidney disease, cholesterol, etc:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST SURGICAL HISTORY**

- 21. If you have had any operations, please list them and indicate the approximate date or your age at the time of the procedure. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**

- 22. Please list all medications or drugs (including non-prescription drugs) which you are taking now. Give the dose and frequency. (If necessary, please check bottle label or consult your pharmacist)

<u>Medication</u>	<u>Dose(mg, mcg, mEq)</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**DRUG ALLERGIES**

- 23. List all medications you are allergic to and the reaction it gives you: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have allergies to: x-ray dye \_\_\_\_\_ adhesive tape \_\_\_\_\_ iodine \_\_\_\_\_

**FAMILY HISTORY**

- 24. Please complete the following and enter all medical conditions of each person. Note age now or at time of death of each family member:

	<u>Deceased (D)</u> <u>Living (L)</u>	<u>Age now or</u> <u>at time of death</u>	<u>Medical conditions now or cause of death</u>
Father	_____	_____	_____

Mother \_\_\_\_\_

Grandmother \_\_\_\_\_

Grandfather \_\_\_\_\_

Sisters: \_\_\_\_\_

Brothers: \_\_\_\_\_

**SOCIAL HISTORY**

- 25. Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorce \_\_\_\_\_ Widowed \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Years married: \_\_\_\_\_
- 26. Please indicate your approximate use/intake of the following:  
Coffee/tea/caffeinated cola \_\_\_\_\_ Tobacco products \_\_\_\_\_ Have you ever  
smoked in the past? How many packs-per-day? \_\_\_\_\_ Alcohol use per week \_\_\_\_\_  
\_\_\_\_\_ Other recreational drugs: \_\_\_\_\_
- 27. Are you currently working? \_\_\_\_\_
- 28. What is your current occupation, or your last job? \_\_\_\_\_
- 29. Would you return to work if you were pain-free? \_\_\_\_\_
- 30. Have you tried to return to work? \_\_\_\_\_
- 31. When was your last day of work? \_\_\_\_\_
- 32. Do you receive compensation or disability payments? \_\_\_\_\_
- 33. Do you have an application pending for compensation or disability payments? \_\_\_\_\_
- 34. Are you suing because of your pain/injury? \_\_\_\_\_
- 35. Have you brought a lawsuit in the past? \_\_\_\_\_
- 36. If yes, what was the outcome? \_\_\_\_\_
- 37. Do you enjoy your work? \_\_\_\_\_
- 38. What was your last grade completed (i.e. 12<sup>th</sup> grade, college degree, masters, etc)? \_\_\_\_\_
- 39. Hobbies \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please draw a circle around any symptoms or conditions in this section which you have had or now have. If your symptoms or condition is not in the list, please write it in.

NEUROLOGICAL: Severe or frequent headaches, unusual head or neck tension, strokes, dizziness, seizures/fits/convulsions, shaking or twitching spells, paralysis of limbs, numbness/tingling of body parts, memory lapses, blackouts, vision changes (blurred, double vision), hearing loss, buzzing in ear, loss of taste or smell. Other \_\_\_\_\_

CARDIOVASCULAR: Lightheadedness, fainting, chest pain, abnormal or fast heartbeat, high blood pressure, anemia, abnormally low blood pressure, varicose veins, blood clots, phlebitis, bleeding disorder, rheumatic fever, heart murmur, atrial fibrillation, congestive heart failure, heart attack, heart disease, frequent and marked swelling of ankles and feet. Other \_\_\_\_\_

RESPIRATORY: Wheezing, shortness of breath, asthma, excessive cough, pneumonia, tuberculosis, pain with breathing, emphysema. Other\_\_\_\_\_

GASTROINTESTINAL: Nausea, vomiting, bloody vomitus, abdominal pain, diarrhea, constipation, ulcers, blood in stool, hiatal hernia, irritable bowel syndrome, colitis, lack of appetite, gallbladder disease, hepatitis. Other\_\_\_\_\_

GENITOURINARY: Urinary incontinence or dribbling, difficulty starting/passing urine, painful urination, excessive urination, blood in urine, kidney stones, increased frequency or urgency in urination, difficulty with sexual function, venereal disease. (Male patients only): Penile or scrotal pain, bloody discharge or pus, prostatitis. Other\_\_\_\_\_ (Female patients only): Vaginal pain, abnormal menstrual flow, breast discharge, breast swelling or lumps, breast pain, nipple changes or irritation, known fibroids or tumors, tubal pregnancies. Other\_\_\_\_\_.  
Date of last menstrual period\_\_\_\_\_. Number of pregnancies\_\_\_\_\_. Number of live births\_\_\_\_\_. Is it possible that you are pregnant now?\_\_\_\_\_(If so, please notify doctor).

EMOTIONAL OR PSYCHOLOGICAL: Emotional illness, depression, excessive worry, insomnia, recurrent feelings of loneliness or hopelessness, severe tension, feelings of worthlessness, recurrent fear, nervous exhaustion, frequent crying, nervous breakdown, frequent nightmares, hysterical attacks, constant unhappiness. Other:\_\_\_\_\_

OTHER: Hemorrhoids, skin problems, sinusitis, diabetes, osteoporosis, arthritis, HIV or AIDS.\_\_\_\_\_