Cardinal Pain Center PA
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):

	All the time	Sometimes	Never
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:

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

	Not Tried	Very helpful	Partly Helpful	Worse
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)**

Medication	Dose(mg, mcg, mEq)	Frequency
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________

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:

	Deceased (D) Living (L)	Age now or at time of death	Medical conditions now or cause of death
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. 12th 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.____