PAIN QUESTIONNAIRE: Date of Packet Completion: ___________________

DEMOGRAPHIC INFORMATION: PLEASE FILL IN ALL INFORMATION.

Name: ____ E-Mail: ___________________________________

Social Security # ___________-__________-__________________ Gender: _______Female _______Male

Date of Birth: ____/____/_______ Driver's License Number/State:____________________________________

Street Address:______________________________________ City: _______________State:______ ZIP:_______

Home Phone: ____________________Work Phone:__________________ Cell Phone:____________________

Emergency Contact: ________________________________ Phone Number: _____________________________

INSURANCE INFORMATION: Please present your cards to the receptionist at time of check-in.

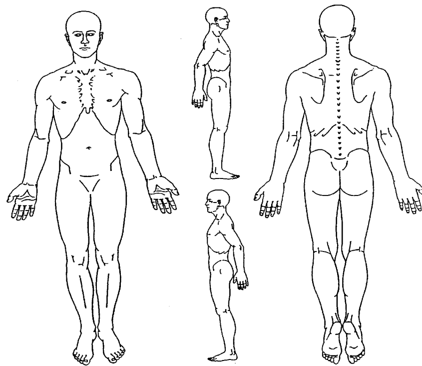
PAIN HISTORY

Chief Pain Complaint**:** _____________________________ Date that your pain started: _______________________________

Is your condition a result of a work related injury (list date)? ______________________________________

Is your condition a related to a particular event (list date)? ____

PLEASE INDICATE ON THE DIAGRAM BELOW WHERE YOUR PAIN IS LOCATED.



Pain Scale

(Circle the number that corresponds to your pain.)

	No Pain										*Worst Imaginable*
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10

How Would You Describe Your Pain? (*Circle all that apply*)

Aching	Penetrating	Stabbing	Tender	Miserable	Twisting	Tiring
Burning	Pressure	Throbbing	Nagging	Gnawing	Unbearable	Dull
Numb	Sharp	Shooting	Shocking	Tingling	Piercing	Crushing

What improves your pain? (*Circle all that apply*)

Heat	Sitting	Walking	Resting in Bed	Medications
Cold	Standing	Massage	Other:	______________________________

What makes your pain worse? (*Circle all that apply*)

Heat	Sitting	Walking	Resting in Bed	Medications
Cold	Standing	Massage	Other:	______________________________

ALLERGIES ☐NO ALLERGIES

MEDICATIONS:	FOODS:	ENVIRONMENTAL:

REVIEW OF SYSTEMS: Please circle all of the following that currently apply to you.

Constitutional: weight changes, change in appetite, loss of appetite, night sweats, fever chills, fatigue, body aches
Eyes: eye pain, impaired vision, changes in vision, transient visual loss, glasses/contacts, double vision, blurry vision
Head: headache, deformity, head trauma, tenderness
ENT: sinus pain, nose bleeds, hearing loss, ear pain, dental problems, sore throat, hoarseness, difficulty swallowing
Breasts: tenderness, swelling, lumps, nipple discharge
Cardiovascular: chest pain, irregular heartbeats, heart murmur, blacking out/fainting, swelling of the feet/ankles, high blood pressure, shortness of breath with exertion, shortness of breath at night, cold/blue extremities, heart flutters, palpitations
Respiratory: shortness of breath, wheezing, hoarseness, non-productive cough, productive cough, snoring, sleep apnea
Gastrointestinal: nausea, vomiting, diarrhea, constipation, reflux/heartburn, abdominal pain, gastroparesis, hemorrhoids, bloody stool
Genitourinary: frequent urination, irregular menses, possible pregnancy, difficulty urinating, incontinence, sexual dysfunction
Integumentary: rash, itching, lesions, color changes
Neurologic: speech difficulties, seizures, falls, head injuries, change in alertness, numbness, loss of consciousness, weakness in limbs, difficulty walking, stroke, muscle twitching, tingling
Musculoskeletal: joint pain, joint swelling, muscle pain, limitation of motion, muscular weakness, muscle cramps, low back pain, stiffness, back surgery, neck pain, neck surgery, mid-back/thoracic back pain, joint stiffness, physical disability, decreased range of motion
Endocrine: loss of hair, cold intolerance, heat intolerance, increased urination, decreased sex drive, increased appetite, increased fatigue, increased thirst, diabetes
Psychiatric: anxiety, depression, difficulty sleeping, suicidal thoughts, homicidal thoughts, mood disorders
Hematologic: easy bleeding, easy bruising, history of blood transfusions, prolonged bleeding, sickle cell anemia, thalassemia
Allergy/Immune: lymph node enlargement/tenderness, lupus, scleroderma, Sjogren's, hepatitis, HIV

PAST MEDICAL HISTORY

- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Back Pain/Lumbago
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cervicalgia/Neck Pain
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Gastroparesis
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Hepatitis/Jaundice/HIV
- ☐ High Blood Pressure
- ☐ Hyperlipidemia/High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Mood Disorders
- ☐ Osteoarthritis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Other:____________________
- ☐ No Past Medical History

PAST SURGICAL HISTORY (Please list previous surgeries you have had including the date.) ☐ No Past Surgical History

MEDICATIONS (including herbal remedies. vitamins, and over-the-counter drugs) OR PROVIDE LIST

DRUG NAME, Strength	DRUG NAME, Strength	DRUG NAME, Strength	DRUG NAME, Strength

FAMILY HISTORY (Mark below and list any immediate family members who have any of the following conditions (i.e. mother, father, grandparents, children, siblings, etc.)

- ☐ Arthritis:______________________
- ☐ Bleeding Disorders:_____________
- ☐ Cancer:_______________________
- ☐ COPD:_______________________
- ☐ Cancer__________________
- ☐ Heart Disease:______________________
- ☐ High Blood Pressure:_________________
- ☐ Mood Disorders:____________________
- ☐ Neurologic Diseases/Stroke:_________________
- ☐ Seizures:______________________________

SOCIAL HISTORY

Marital Status: (*Circle One*) Married Divorced Single Widowed Occupation:____________________________________
Smoking: None Packs per day_____ Number of years_____
Alcohol: None Drinks per day____ Drinks per week_____
Drug Abuse (past or present/ illicit or prescription):____