Pain History Questionnaire

PLEASE HIGHLIGHT YOUR ANSWER WHEREVER APPLICABLE

Name: _____Male __ Female __ Date: ___ / ___ / _____

DOB: ___ / ___ / _____ Age (Years): _____ ☐ Dover ☐ Wilmington ☐ Lewes

Please provide the following medical information to the best of your ability:

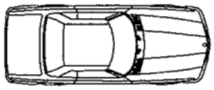
1. **Describe your main reasons for this visit (I.E. Chief Complaint):**

_____

_____

2. Is your pain related to an accident / injury? YES NO* When? (Month/Day/Year_____

(If your visit is **not related to an accident or injury, please skip to Question 3 below)*

1. Motor Vehicle Accident? YES / NO  Driver / Passenger Seat Belt / Air Bag Deployed Indicate site of impact: "P" = Primary "S" = Secondary Did you hit your head? YES NO Any loss of consciousness? YES NO Memory Problems? YES NO Police Notified? YES NO Visit to Emergency Room YES NO	**2. Work Related Injury:** YES NO Has this injury been accepted as a Worker's Compensation claim? YES NO

Describe your accident / injury or history of problem in detail:

_____

_____

_____

_____

_____

_____

3. Have any tests (x-rays, CT Scan, MRI) been done to evaluate this problem? YES NO

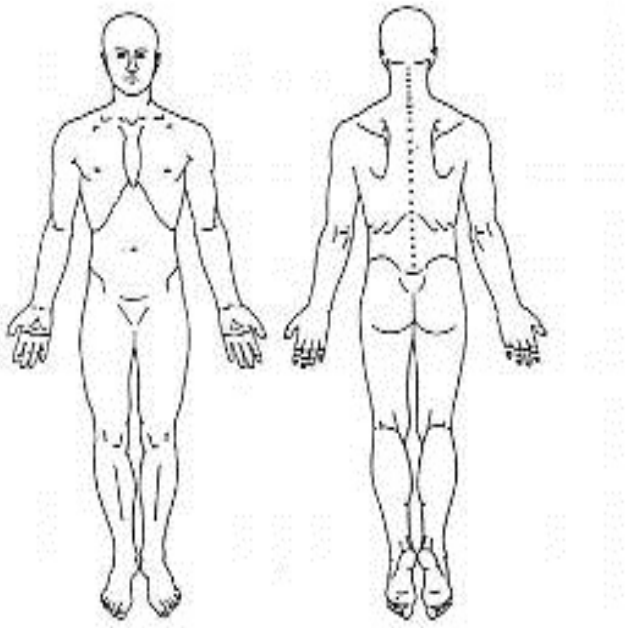
Tests	Facility Name	Location & Phone	Physician Name	Results
x-ray				
CT Scan				
MRI Scan				
Bone Scan				
EMG Testing				
Other				

History (cont'd) Name: _____ Reviewed By: _____

4. Have any other pain management physicians evaluated you for this problem? YES NO

Physicians Name	Location	Treatment History: Medications, Therapies, Injections (List and Describe)

5. INSTRUCTIONS: Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.,)



Type of your pain: PLEASE HIGHLIGHT YOUR ANSWER

Burning	Tiring	Nagging
Stabbing	Exhausting	Shooting
Miserable	Unbearable	Sharp
Numb/Tingling	Aching	Tender
Penetrating	Throbbing	

1. Please mention the level of your primary pain from 0 (no pain) to 10 (worst pain imaginable) for the following:

   PRESENT level of pain:

   WORST pain you've had:

   AVERAGE level of pain (day to day):

2. Your present pain is… Constant Intermittent Worse in the… A.M. P.M.

3. Have your symptoms gotten Worse Better No Change

4. Which of the following activities increase your pain: **PLEASE HIGHLIGHT YOUR ANSWER**

   Sitting Standing Walking Lifting Housework
   Coughing Sneezing Lying flat on back Lying flat on stomach

5. What activities decrease your pain? **PLEASE HIGHLIGHT YOUR ANSWER**
   Sitting Standing Walking Lying flat on back Lying flat on side with knees bent

6. Do you have any pain going down your: Right Arm Left Arm Right Leg Left Leg

History (cont'd) Name: _____ Reviewed By: _____

7. Do you have difficulty sleeping because of pain? YES NO

8. Please rate your ability to cope with pain:
(0 = Not able, 10= Very able)

9. Please rate your ability to perform activities of daily living, such as hygiene, household chores, transportation, etc.:
(0 = Not able, 10 = Very able)

10. Please rate your ability to function and interact with family and friends:
(0 = Not able, 10 = Very able)

11. Please rate your ability to work in your usual occupation:
(0 = Not able, 10 = Very able)

6. Functional History: PLEASE HIGHLIGHT YOUR ANSWER

Pain is limiting the Activity			**Comments**				**Comments**
Sitting	Yes	No		Squatting	Yes	No	
Standing	Yes	No		Crawling	Yes	No	
Walking	Yes	No		Climbing	Yes	No	
Driving	Yes	No		Repeated arm motions	Yes	No	
Bending	Yes	No		Repetitive use of wrist/hands	Yes	No	
Turn/Twist	Yes	No		Reaching above shoulders	Yes	No	
Kneeling	Yes	No		Foot Controls	Yes	No	
Sleeping	Yes	No		Yard Work	Yes	No	
Appetite	Yes	No		Housework	Yes	No	
Working	Yes	No		Sexual Activity	Yes	No	
Emotion	Yes	No		Other: Specify:	Yes	No	
Concentration	Yes	No					

7. Past Accidents/ Injuries- PLEASE HIGHLIGHT YOUR ANSWER

Injury	Body Part (s) Injured	Treatment	Outcome Completely Healed Residual Pain (%)	Lawyer?	Case Open??
1st Accident Date:				Yes No	Yes No
2nd Accident Date:				Yes No	Yes No
Work Injury: Date:				Yes No	Yes No

8. Pain Medications that you are taking for pain: PLEASE HIGHLIGHT YOUR ANSWER

Name	Side effects?	Does it help?
		YES NO
		YES NO
		YES NO

History (cont'd) Name: _____ Reviewed By: _____

9. Medications and other treatments that you have tried in the past PLEASE HIGHLIGHT YOUR ANSWER:

Opioids: Fentanyl (Actiq, Duragesic), Demerol, Hydrocodone (Vicodin, Lortab, Norco), Tramadol, Morphine, Oxymorphone, Methadone, Oxycodone, Hydromorphone, Tapentadol, Propoxyphene (Darvocet), Buprenorphine (Suboxone, Subutex), Codeine

Anti-Inflammatories / Tylenol: Diclofenac, Oxaprozin, Meloxicam, Nabumetone, Aspirin, Indomethacin, Ibuprofen, Acetaminophen, Celecoxib, Etodolac, Naproxen, Flector patch

Muscle Relaxants: Baclofen, Methocarbamol (Robaxin), Carisoprodol (Soma), Cyclobenzaprine (Flexeril), Metaxalone (Skelaxin), Tizanidine (Zanaflex)

Antidepressants: Cymbalta, Nortriptyline, Remeron, Wellbutrin, Effexor, Paxil, Serzone, Zoloft, Amitriptyline, Pristiq, Imipramine (Tofranil), Lexapro, Fluoxetine (Prozac), Trazodone

Sleep Aids: Zolpidem (Ambien), Lunesta, Rozerem, Xyrem, Restoril, Sonata

Other Medications: Axert, Hydroxyzine, Lyrica (Pregablin), Tegretol, Zonegran, Buspar, Imitrex, Maxalt, Topamax, Frova, Keppra, Gabapentin (Neurontin), Vistaril, Gabitril, LIdoderm Patch, Relpax, Zomig, Bupenorphine, Naloxone

Other Herbal Remedies:

Marijuana:

Any other beliefs / Concerns:

10. Pain relieving injections (Spinal Injections) that you have had in the past: PLEASE HIGHLIGHT YOUR ANSWER

Name	Side effects?	Did it help?
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO

11. Past Spine Surgical History: PLEASE HIGHLIGHT YOUR ANSWER

Low Back Surgery: **Yes NO** Mid Back Surgery: **Yes NO** Neck Surgery: **Yes NO**

12. Please list all spine surgeries:

Type of Surgery	When and Name of Surgeon

13. Please list all other surgeries, excluding the spine:

Type of Surgery	When and Name of Surgeon

History (cont'd) Name: _____ Reviewed By: _____

14. Other treatments You might have had in the past: **PLEASE HIGHLIGHT YOUR ANSWER**

Name		Did it help?
TENS unit		YES NO
Physical Therapy		YES NO
Chiropractic Therapy		YES NO
Massage Therapy		YES NO
Acupuncture		YES NO
Counseling		YES NO
Other (Specify):		YES NO

17.

Describe your treatment expectations: PLEASE HIGHLIGHT YOUR ANSWER

Spinal Injections? YES NO NOT SURE Spinal Surgery? YES NO NOT SURE
Opioid Medications? YES NO NOT SURE Non Opioid Medications? YES NO NOT SURE
Therapies? YES NO NOT SURE Acupuncture? YES NO NOT SURE
Marijuana **(*SELF PAY*)** YES NO NOT SURE TMS -Brain Stimulation? YES NO NOT SURE

15. Some of the pain medications make patients to become dependent and at time make them addicted to the medications. Are you aware of such issues? **YES** **NO**

16. Are you aware of any of your family members, friends and relatives who have experienced problems with prescription medication dependency and addiction? **YES** **NO**
If YES, Your comments: _____

17. Are you willing to change your prescription medications if the treating physician were to suggest some changes?
YES **NO** If NO, Your comments:_____

18. Past Medical History - **PLEASE HIGHLIGHT YOUR ANSWER**

Diabetes	Yes	No		Thyroid Problems	Yes	No	
High Blood Pressure	Yes	No		Allergy Problems / Therapy	Yes	No	
Heart Disease	Yes	No		Kidney / Bladder / Prostate	Yes	No	
Heart Attack	Yes	No		Neurological problems	Yes	No	
Heart Surgery	Yes	No		Addiction /Substance abuse	Yes	No	
High Cholesterol	Yes	No		Mental Health / Psychiatric	Yes	No	
Respiratory Problems	Yes	No		Other:	Yes	No	
Stomach Problems	Yes	No		Bleeding Disorder	Yes	No	

19. All other regular medications if any: (ex: for blood pressure, diabetes, ulcers, blood thinners, over the counter meds)

Name	Dose	Prescribed By?	Side Effects?	Comments

20. Please list any **Drug Allergies:**

Name	Reaction	Name	Reaction

History (cont'd) Name: _____ Reviewed By: _____

IV Dye Allergy: YES NO Latex Allergy: **Yes NO** **Seafood / Shell Fish Allergy**: **YES NO**

21. Family Medical History - Please check the "YES" or "NO". For "YES" answers, please explain relationship.

Disease	YES	NO	Relationship	Disease	YES	NO	Relationship
Diabetes				Thyroid problems			
Hypertension (high blood pressure)				Allergy problems/Therapy			
Respiratory problems				**Prescription Drug Addiction**			
Stomach problems				Other medical diagnosis			
Bleeding Disorder				**Substance abuse/Illicit drugs**			
Cancer				**Anesthesia problems**			
Rheumatoid Arthritis				**Back Pain or Chronic Pain Problems**			

Are you currently: ☐ Single ☐ Married ☐Widowed ☐ Divorced ☐Separated?

Is your significant other working? ☐YES* ☐NO *Type of work: _____

Where do you live? ☐Trailer Home ☐Apartment ☐2+ Story House ☐Ranch-style House

Transportation? ☐Own a car ☐Friends car ☐Public Transportation ☐Family member car

22. Social History:

	YES	NO	Comments		YES	NO	Comments
Smoking				Working			
Drinking				Disabled			
Marijuana *(Regular or Recreational)*				Applying for Disability			
Cocaine				On Short term Disability			
IV drug usage (Heroin)				On Long term Disability			
Incarceration (Arrests)							

23. If you are not working now, do you see yourself? <u>PLEASE HIGHLIGHT YOUR ANSWER</u>

☐Returning to the same job ☐Modified work ☐Changing jobs - same employer ☐Changing jobs - different employer ☐Retraining or returning to school ☐Applying for early retirement

24. Review of Systems: PLEASE HIGHLIGHT YOUR ANSWER *Height: ____Weight: _____ BMI: _____*

GENERAL:	Change of Appetite	Weight Loss or Gain	Fatigue	Fever	
NEURO:	Weakness	Numbness	Tingling	Headaches	Tremors
GI:	Nausea	Vomiting	Reflux	Constipation	Diarrhea
PSYCH:	Depression	Anxiety	Memory Loss	Sleeplessness	Mood Changes
MUSCULO-SKELETAL:	Spasms	Cramps	Joint Pain	Swelling	Stiffness
RESPIRATORY:	Cough	Breathless	Chest Pain		
CARDIAC:	Chest Pain	Palpitations	Leg Edema		
ENDOCRINE:	Hot or Cold Intolerance	High Sugar	Excess Thirst	Increased Urination	
ENT:	Change in Vision	Decreased Hearing	Change in Voice		
GU:	Loss of Bladder	Increased Frequency	Kidney Stones		

25. I certify that the above information is true to the best of my knowledge.

Print Name: _____ INITIALS: _____ Date: _____

<u>History (cont'd)</u> Name: _____ Reviewed By: _____