

Current Date _____

THE PAIN MANAGEMENT CENTER



Appointment Date _____

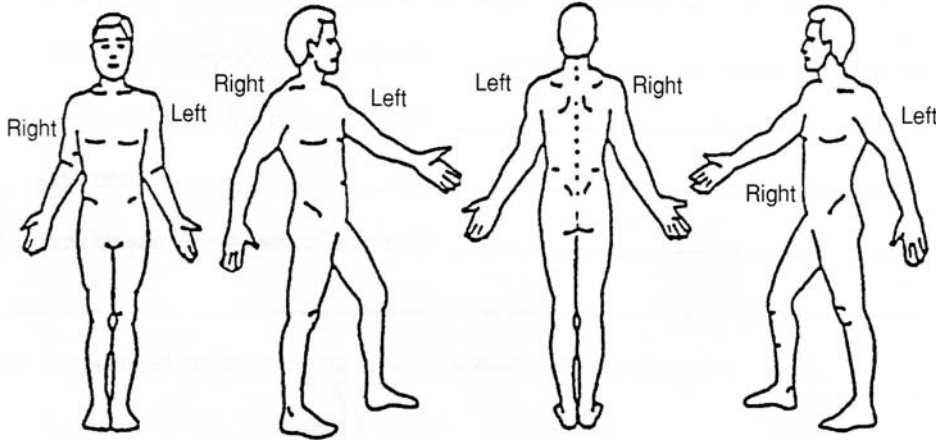
PAIN QUESTIONNAIRE

Name _____ Date of Birth _____

1. When did your pain begin? Mo _____ Day _____ Yr _____

2. How did your pain begin? _____

3. Please shade in the areas you are having pain:



	Scale	
No pain	0	
	1	
Mild, annoying pain	2	
	3	
Nagging, uncomfortable, troublesome pain	4	
	5	
Distressing, miserable pain	6	
	7	
Intense, dreadful, horrible pain	8	
	9	
Worst possible, unbearable, excruciating pain	10	

4. Using the pain scale at the right, rate your pain from 0-10:

At its worst _____ At its best _____ Today _____

5. Circle the items that best describe your pain:

- Aching
- Cold
- Electric Shock
- Numb
- Shooting
- Squeezing
- Throbbing
- Biting
- Cramping
- Hot
- Persistent
- Sore
- Stabbing
- Tight
- Burning
- Dull
- Miserable
- Sharp
- Spasms
- Tender
- Tingling
- Unbearable

6. How often does your pain occur? (check the ONE that is most accurate)

Constantly _____ Comes during the day _____ Starts in the morning _____

Intermittently occurs during the day _____ Evening/bedtime _____

7. Circle the items that increase your pain:

- Arching Back
- Driving
- Ice
- Physical Therapy
- Sitting
- Stepping Down
- Twisting
- Bending
- Getting Up
- Lifting
- Reaching
- Sneezing
- Stepping Up
- Walking
- Coughing
- Heat
- Lying Down
- Sex
- Standing
- Stress
- Weather

8. Circle the items that decrease your pain:

Heat Massage Pressure Standing Other: _____
 Ice Medicine Relaxation Walking
 Lying Down Physical Therapy Sitting

9. Does your pain interrupt your sleep? _____ +

How often? _____

10. Circle any of the following that you have tried to relieve your pain.

Acupuncture Biofeedback Counseling Massage Physical Therapy Traction
 Rest Chiropractor Manipulation Hypnosis Pain Blocks TENS unit
 Other: _____

11. Have you ever had any pain blocks or cortisone (steroid) injections done for your pain? _____

If yes, when? _____ By whom? _____

Did they help? _____ If yes, for how long? _____

12. List any pain medications you have tried and their effect on your pain:

Medication	Dosage	Effect on Pain
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

{
 No Improvement
 Slight Improvement
 Significant Improvement

13. Have you had any of the following tests done for this condition?

	Date	Where
X-rays		
MRI		
EMG		
Myelogram		
CT Scan		
Bone Scan		
Other		