ORTHOPEDIC & SPORTS MEDICINE CENTER
OSMC
THE PAIN MANAGEMENT CENTER

PAIN QUESTIONNAIRE

Current Date _____

Appointment Date _____

Patient Name _____ **Date of Birth**_____

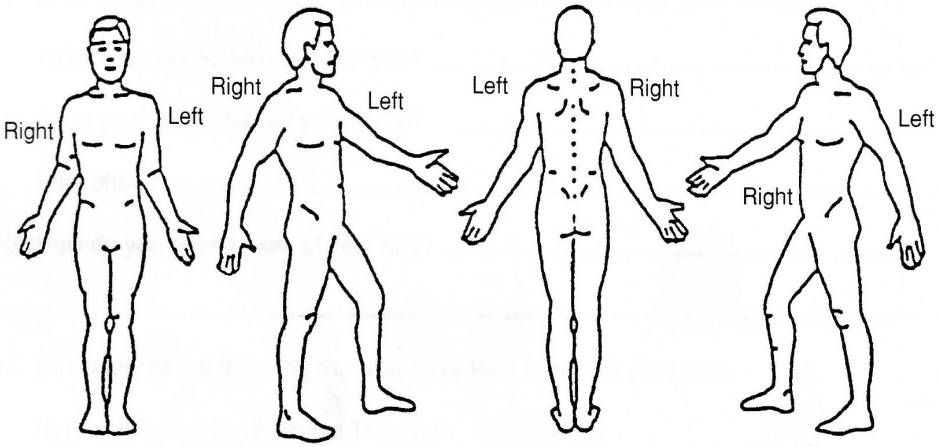
1. **When did your pain begin?** Mo _____ Day _____ Yr _____

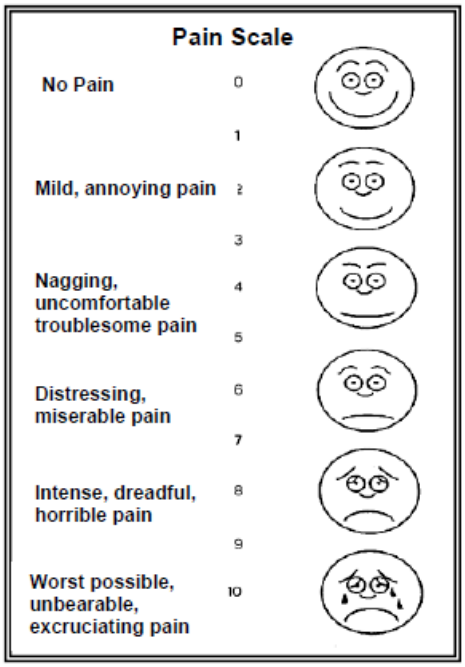
2. **Is there a lawsuit involved as a result of a related accident or injury?** _____

3. **How did your pain begin?** _____

_____

4. **Please shade in the areas you are having pain:**





5. **Using the Pain Scale at the right, rate your pain from 0-10:**

At its worst _____ At its best _____ Today _____

6. **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

7. **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 _____

8. **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

Patient Name _____ **Date of Birth**_____

9. Circle the items that decrease your pain:

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

10. Does your pain interrupt your sleep? _____

How often? _____

11. 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: _____ _____ _____

12. 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? _____

13. List any <u>pain</u> medications you have tried and their effect on your pain:

No Improvement
Slight Improvement
Significant Improvement

Medication	**Dosage**	**Effect on Pain**

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

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