

Pain Consultants of Central Illinois, LLC
Pain Questionnaire

Name: _____

DOB : _____

Address: _____

Sex: M ____ F ____

Home Phone #: _____

S.S.#: _____

Marital Status: M ____ S ____ D ____ W ____

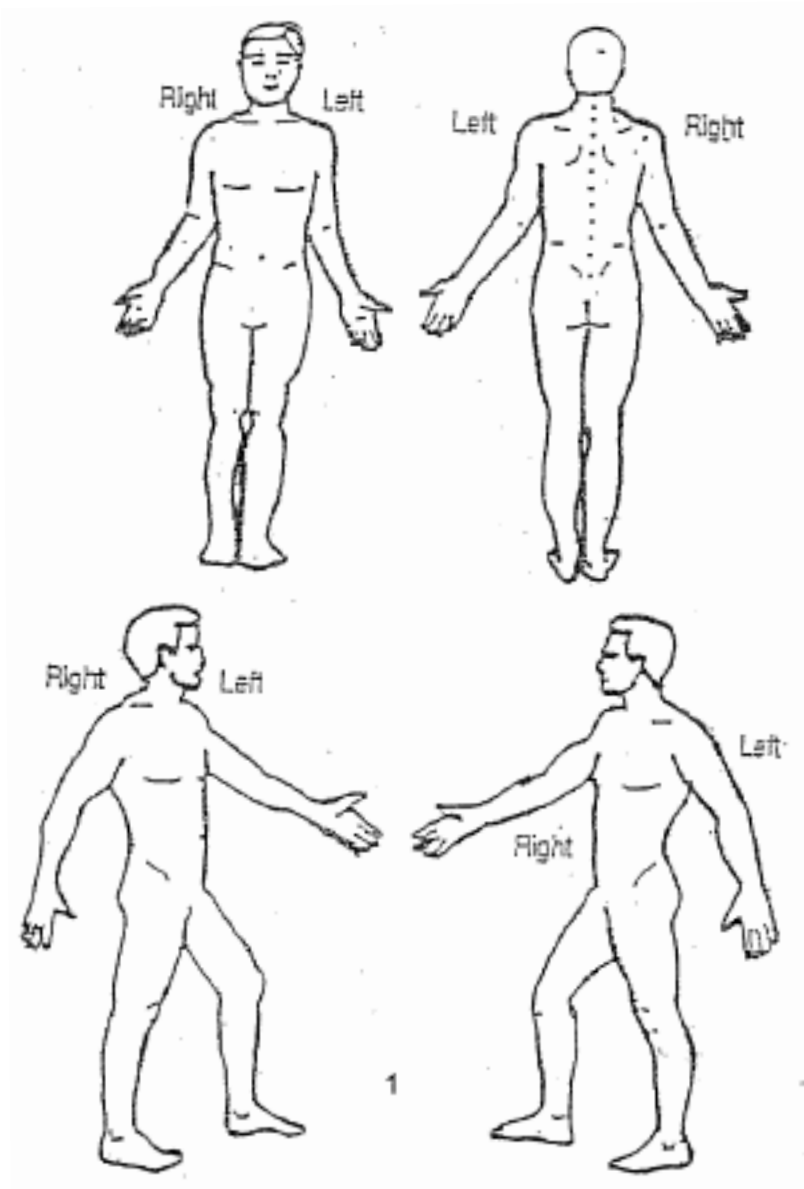
Employer/Occupation: _____

Work Phone #: _____

Referring Physician: _____

Primary/Family Physician: _____

Please mark the painful sites in your body on the diagram below:



Pain History:

1. Where is your pain? (Please list most severe first):

A. _____

B. _____

C. _____

2. Describe what your pain feels like?

- Burning Shooting Throbbing Crushing
 Dull & achy Electrical Sharp Pulling
 Toothache like Stabbing Other (describe): _____

3. Does your pain travel anywhere? NO If YES, where?

4. Please indicate the amount of pain you by placing an 'X' on the scale below. '0' being no pain at all and '10' being the most severe pain ever experienced.

Today: 0 10

Average day: 0 10

5. When did your pain begin (date): _____

6. How did the pain start/what do you think caused it? If this was a work injury or a motor vehicle accident, please provide details. Please include any pain prior to the incident.

7. Please describe the course of your pain during the day:

- Constant Intermittent Constant but varies over hour to hour or day-to-day

8. What makes this pain worse?

- Sitting Standing Walking uphill Lifting Bending
 Lying flat Driving Climbing stairs Straining Laughing
 Coughing Sneezing Sex Walking downhill Other: _____

9. What makes this pain better?

- Medication Massage Lying down Standing Walking
 Sitting Heat Ice Applying pressure Bending forward
 Other: _____

10. Are there other symptoms associated with your pain?

- Weakness Sweating Dizziness Fever Chills Insomnia
 Night Sweats Constipation Headaches Falling Fainting
 Dropping things Other (please describe) _____

11. Have any of the following occurred over the painful area?

- Swelling Redness Blue discoloration Blanching of the skin

12. Is your sleep disturbed due to pain? Yes No If YES, please answer the following:

- I usually go to bed at _____ o'clock.
- I first wake up at _____ o'clock.
- I usually get about _____ hours of sleep at a time.
- Usual percentages of time I get disturbed sleep only due to Pain: _____

13. Have you gone to the ER for this pain? YES NO

- How often does this happen _____
- What treatment is given _____

Medical History:

Cardiovascular system:

- None High Blood Pressure Chest Pain Heart Attack Aneurysm
- Circulation Problems Irregular Heart Rate Stroke/CVA Mitral Valve Prolapse
- Pacemaker/AID Stent Other: _____

Nervous System:

- None Neuropathy Seizures Meningitis Other _____

Respiratory System:

- None Asthma Pneumonia Emphysema Other _____

Gastrointestinal System:

- None Ulcers Hiatal hernia Hernia Nausea/Vomiting/Diarrhea/Constipation

Metabolic Diseases:

- None Diabetes Thyroid Liver disease Bleeding problem Bruising tendencies

Genitourinary System:

- None Pregnancy Kidney Failure/Problems Other _____

Musculoskeletal System:

- None Arthritis Muscle aches/spasms Congenital spine problems Chronic fatigue

Infectious Diseases:

- None Hepatitis AIDS/HIV+ Other _____

Other (abuse, ADD, Bipolar) _____

Cancer (Site) _____

Surgical History:

Surgeries (with dates...list those NOT for this problem):

Allergies to Medications:

Medications:

Over the counter, prescription and herbal: _____

Anticoagulants: please circle those you are currently using: Cumadin, Plavix, Pletal, Heparin, Trental

Other: _____

Past Treatments for your Pain

Have you had any surgeries for your pain? YES NO

- a. If YES, please list all the surgeries pain (with dates by physician): _____

Have you had any "Pain Blocks"? YES NO

If YES, please list all the procedures (injections, etc.) below with dates if known.

- a. _____ d. _____
b. _____ e. _____
c. _____ f. _____

Have you had any Physical Therapy for this problem? YES NO

If YES, when and how long?

List all medications tried and circle all those that were helpful: _____

Family, Work, Social History:

Does this problem or related problems run in the family? YES NO

Explain _____

Where do you work? _____

What do you do? _____

How has this problem affected your job? _____

If you are not working, is it because of this problem? _____

How long have you been unable to work? _____

How has this problem affected you socially?

Can you still perform activities of daily living? If NO, what activity is that:

Can you walk normally? _____

Do you need a wheelchair, walker or other device? _____

Are you in need of a Visiting Nurse or Home Healthcare Services? _____

Are you able to drive? _____

Can you cook, clean and care for yourself? _____

Current height _____ weight _____ Has this changed recently? _____

Lifestyle

Smoking: Tobacco YES NO How much? _____ How

long? _____

Marijuana YES NO How much?_____ How long?_____

Alcohol: YES NO Type_____ Quantity_____

Frequency_____

Drugs: Do you use illegal drugs? YES NO Type_____ Quantity_____

Frequency_____

Is there a personal or family history of addiction? YES NO Rehab? _____

Learning Assessment:

Do you have any learning disabilities or difficulties understanding directions, medications or instructions?

Past Diagnostic Studies:

Please circle all tests you have had for this pain (**please write the dates if known, & where done**):

X-Rays: _____ MRI: _____

Myelogram: _____ CT Scan: _____

Bone Scan: _____ EMG: _____

Other: _____

Above Hx reviewed w/patient and confirmed: _____(MD initials)

PHYSICAL EXAM – SEE ATTACHED SHEET

DIAGNOSIS:

ASSESSMENT / PLAN:

_____ MD DATE: _____