HSHS St. Anthony's Memorial Hospital

CENTER FOR INTERVENTIONAL PAIN MANAGEMENT PAIN QUESTIONNAIRE

*Your First Visit With The Pain Center Physician is a Consultation, You May or May Not Receive an Injection on the First Visit. Thank You.

*Please fill out form completely.

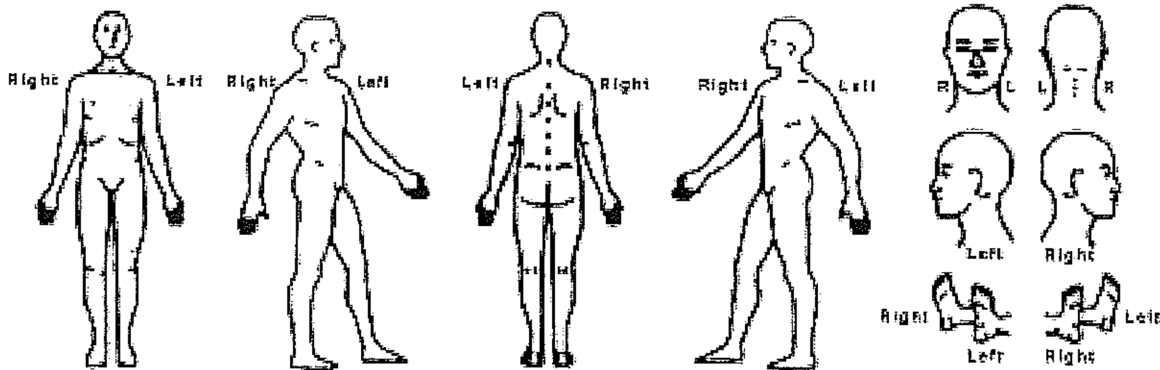
Name:______________________ Date of Birth:__________Age_____

Address ____________________ Sex: Male_____ Female______

___________________________ Home Phone:__________________

Referring Physician:____________________ Primary Physician_____________

Please use the diagram below to mark the areas of your pain.



1. Chief Complaint (main reason for Visit Today)? ______________________
2. Where is your pain? (Please list most severe First)

A ____________________ B ____________________

C ____________________ D ____________________

3.When did the pain begin? (Date)____________________

4. How did the pain start? /What do you think caused it?

____

5. Does the pain radiate (travel) anywhere? ❑ no, If yes where?

____

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6. On a Scale of 0–10 please indicate (circle) the amount of pain you experience. '0' being no pain at all and '10' being the most severe pain you have ever experienced.

Today: 0 1 2 3 4 5 6 7 8 9 10
The best your pain gets: 0 1 2 3 4 5 6 7 8 9 10
The worst it gets: 0 1 2 3 4 5 6 7 8 9 10

7. Describe what your pain feels like:

❑ Burning ❑ Shooting ❑ Throbbing ❑ Crushing ❑ Dull
❑ Electrical ❑ Sharp ❑ Achy ❑ Pulling ❑ Cramping
❑ Toothache like ❑ Stabbing ❑ Hot ❑ Numbness ❑ Tingling
❑ Other(describe):______________________________

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

❑ Constant ❑ Intermittent ❑ Constant but varies ❑ Hour to Hour and/or ❑ Day to day

9. Your pain is worse in the:

❑ Morning ❑ Daytime ❑ Evenings ❑ Middle of the night ❑ Varies

10. What makes the pain worse?

❑ Sitting ❑ Walking ❑ Lifting ❑ Bending backward
❑ Standing ❑ Driving ❑ Laughing ❑ Bending forward
❑ Climbing stairs ❑ Straining ❑ Sneezing ❑ Coughing
❑ Laying flat ❑ Sex ❑ Using the bathroom
❑ Other______________________________

11. What makes it better?

❑ Medication ❑ Massage ❑ Laying down ❑ Sitting
❑ Ice ❑ Leaning forward ❑ Rest ❑ Heat
❑ Standing ❑ Applying Pressure ❑ Leaning backward ❑ Walking
❑ Other (Please explain)______________________________

12. Are there other symptoms with your pain?

❑ New or progressive weakness ❑ Night sweats ❑ Dropping things ❑ Sweating
❑ Constipation ❑ Headaches ❑ Dizziness ❑ Fever ❑ Chills
❑ Urinary incontinence ❑ Bowel incontinence ❑ Urinary retention ❑ Numbness
❑ Other Please explain ______________________________

13. Have you had any of the following over the painful area?

❑ Swelling ❑ Blanching of the skin ❑ Light touch causes pain
❑ Redness ❑ Hair or nail changes
❑ Blue Discoloration ❑ Rash

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14. Has this problem affected your job?______________________________
____

15. How has this problem affected you socially?______________________
____

16. Can you still perform activities of daily living? ❑ Yes ❑ No? If no please explain
____

17. Is nutrition affected by pain or medications? ❑ Yes ❑ No

18. Is your sleep disturbed by your 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.

19. Past treatments for your pain?

Previous Surgery for pain? Please list surgery(s) ,date(s), Surgeon(s)
____
____

Is your pain the same as before surgery or different? ______________________

20. Have you had pain injections before? ❑ Yes ❑ No

If yes please list below and dates if known:

a. ____________________ d. ____________________
b. ____________________ e. ____________________
c. ____________________ f. ____________________

21. Have you done Physical Therapy for this pain? ❑ Yes ❑ No Date of last PT__________

– If yes how many days/week and how many weeks did you do? ______________

22. Have you tried:

TENS unit? ❑ Yes ❑ No	Biofeedback? ❑ Yes ❑ No	Chiropractor? ❑ Yes ❑ No
Back Brace ? ❑ Yes ❑ No	Ice/Heat? ❑ Yes ❑ No	Massage? ❑ Yes ❑ No
Acupuncture? ❑ Yes ❑ No	Meditation ❑ Yes ❑ No	Psychotherapy ❑ Yes ❑ No

23. Have you seen anyone else for your pain?

Neurology   Rheumatology   Physiatrist   Orthopedist   Neurosurgery

Other pain physician? Etc? Please list______________________________
____.

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24. Are you involved in any litigation or lawsuit regarding your pain? ❑ Yes ❑ No

25. Are you seeking workman's compensation because of your pain? ❑ Yes ❑ No

26. Are you on disability? ❑ Yes ❑ No Reason?______________________

Trying to get on disability? ❑ Yes ❑ No

27. Was the pain result of a Motor Vehicle accident? ❑ Yes ❑ No
Is there an auto insurance claim? ❑ Yes ❑ No

Diagnostic Studies for your pain? (circle all that apply and dates and where you got them)

X–ray______________ MRI______________ CT______________

EMG______________ Bone Scan______________ Myleogram______________

Ultrasound______________ Other______________________

Social History

Single Married Divorced Widowed Children ___#______

Occupation/Employer:______________________

Status? Full time, Part time, Retired, Unemployed

Smoking Tobacco ❑ Yes ❑ No Chewing Tobacco ❑ Yes ❑ No

Marijuana ❑ Yes ❑ No

Alcohol ❑ Yes ❑ No

Illegal drugs? If so what type______________ How do you use it?______________

Is there a family history of addiction? ❑ Yes ❑ NoWhat type?______________

Other:______________________________________

Pharmacy: Name______________________ Phone
#______________________

Address______________________ City______________ State______________

I, understand, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

__________ __________ X______________________

Date Time Patient/Legal Guardian

X______________________ ______________________

Person signing on patients behalf/relationship Reason patient unable to sign