PATIENT INFORMATION QUESTIONNAIRE

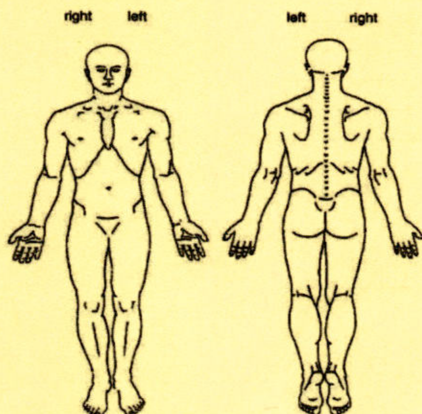
Last	First	Middle	Male/Female	Age

Referring Physician	**Primary Care Physician**
Practice Name: ____________	Practice Name: ____________
Physicians Name: ____________	Physicians Name: ____________
Address: ____________	Address: ____________
____________	____________

Describe your most disabling/severe pain:

____

____



How and when did your pain begin? ________ (month/year)

- ☐ Work accident
- ☐ Home accident
- ☐ Auto accident
- ☐ Other: ____________
- ☐ Following surgery/illness
- ☐ Other accident
- ☐ Unknown

Describe the circumstances around the onset of your pain:

____

____

Please mark the area(s) on the diagram above in which you are in pain.

Circle the number that best describes how severe your pain is

0	1	2	3	4	5	6	7	8	9	10
no pain		mild		discomfort		distress		horrible		worst pain imaginable

Duration of pain

☐ < 1 week ☐ 1-4 wks ☐ 1-3 months
☐ 3-6 months ☐ 6-12 months ☐ > 1 year

How often does the pain occur?

☐ Continuously ☐ Several times per day
☐ Intermittent ☐ Occassionally ☐ Less than daily

How has the pain intensity changed since it began?

☐ Increased ☐ Decreased ☐ No change

Select one or more items below to describe the nature of your pain:

☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/burning ☐ Aching ☐ Stabbing

How do the following factors affect your pain? (check one blank per number)

	Better	Worse	No effect		Better	Worse	No effect
1. Heat	☐	☐	☐	6. Climate	☐	☐	☐
2. Cold	☐	☐	☐	7. Fatigue	☐	☐	☐
3. Lying down	☐	☐	☐	8. Coughing	☐	☐	☐
4. Sitting	☐	☐	☐	9. Massage	☐	☐	☐
5. Walking	☐	☐	☐	10. Alcohol	☐	☐	☐

Which of the following activities are affected by your pain?

☐ Falling asleep ☐ Social Interaction ☐ Household Chores
☐ Staying asleep ☐ Sexual Activity ☐ Work/School ☐ Leisure

Give the dates of the tests you have had to diagnose your pain:

X-rays ____________________ Myelogram ________________
CT Scan ___________________ Nerve conduction/EMG __________
MRI ____________________ Other ________________________

List the name(s) of other specialists including previous pain clinics/specialists you have seen for you pain:

Name	Specialty	Dates seen

Give the dates of treatments you have had for your pain

Acupuncture ________ Exercise ________ Physical Therapy ________
Biofeedback ________ Facet block ________ Psychotherapy ________
Brace ________ Hypnosis ________ Surgery ________
Chiropractor ________ Massage ________ TENS unit ________
Epidural ________ Nerve block ________ Trigger Point ________
Other ____

Do you have any drug allergies?

☐ ***No*** known drug allergies ☐ ***Yes*** (please list drug and reaction):
____

List all medications you are currently taking:

	Medication	Dose		Medication	Dose
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Past pain medications tried:

____
____
____

Past Surgical History

Surgery	Year	Surgery	Year

Family History

Please check any of the conditions below that run in your family:

☐ Arthritis ☐ Cancer ☐ Depression ☐ Diabetes ☐ Heart disease
☐ Lupus ☐ Stroke ☐ Other: ______________