PATIENT INFORMATION QUESTIONNAIRE

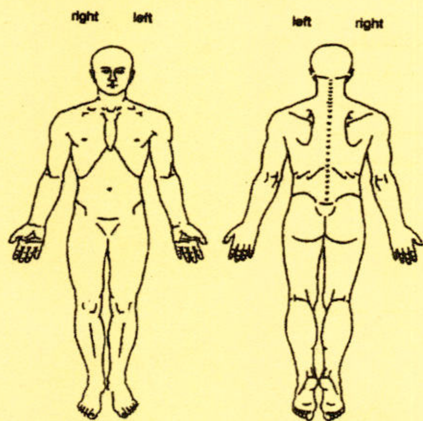
Last ______ First ______ Middle ______ Male/Female ______ Age ______

Referring Physician
Practice Name: ______
Physicians Name: ______
Address: ______

Primary Care Physician
Practice Name: ______
Physicians Name: ______
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
1. Heat	☐	☐	☐
2. Cold	☐	☐	☐
3. Lying down	☐	☐	☐
4. Sitting	☐	☐	☐
5. Walking	☐	☐	☐
6. Climate	☐	☐	☐
7. Fatigue	☐	☐	☐
8. Coughing	☐	☐	☐
9. Massage	☐	☐	☐
10. Alcohol	☐	☐	☐

Which of the following activities are affected by your pain?
☐ Falling asleep
☐ Staying asleep
☐ Social Interaction
☐ Sexual Activity
☐ Household Chores
☐ 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:________________