Sunrise Institute
For Pain Management

6535 Rochester Road, Suite 102
Troy, MI 48085

Comprehensive Pain Questionnaire

Complete this form before your first appointment at SUNRISE INSTITUTE FOR PAIN MANAGEMENT. Your careful answers will help us to understand your pain problem and design the best treatment program for you.

You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Workman's Compensation Claims).

Name _____
Last First Middle Initial

Address_____
Street Address

_____
City State Zip

Home Phone _____

Referring Physician _____ Other Referral _____

Sex: M ☐F☐

Age _____ Race ☐Asian-American ☐Afro-American
☐White ☐Hispanic
☐Other

CHARACTERISTICS OF PAIN

What is the main problem for which you are seeking treatment at Sunrise Institute For Pain Management? (What type of pain? Back, neck, leg, joint, etc:)

_____
_____
_____

PAIN INTENSITY

Please circle level of your pain currently.

0 1 2 3 4 5 6 7 8 9 10
least most

PAIN DURATION

How long have you had your current pain problem (in years and/or months)?

_____ (#)year's _____(#)months

ONSET OF PAIN

How did your current pain start?

- ☐ Injury at work
- ☐ Treatment caused (e.g., radiation, surgery, etc.)
- ☐ Injury, not at work
- ☐ Motor vehicle accident
- ☐ Unknown

Please explain

_____

_____

_____

PROGRESSION OF PAIN

☐ Gradual onset

☐ Rapid onset

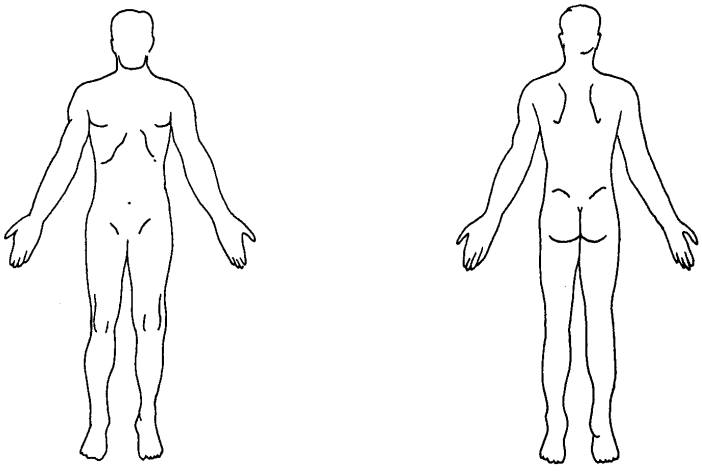
PAIN QUALITY

How would you describe the pain?

☐burning	☐sharp	☐cutting	☐throbbing
☐cramping	☐numbness	☐dull, aching	☐pressure
☐pins and needles	☐shooting	☐other_____	

PAIN LOCATION

Please indicate the location(s) of your pain:



Front *Back*

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

SLEEP DISTURBANCES

Do you have difficulty failing asleep?	☐Yes ☐No
Do you have difficulty remaining asleep?	☐Yes ☐No
Are you ever awakened by the pain?	☐Yes ☐No

RELIEVING AND AGGREVATING FACTORS

How do the following affect your pain? (please check one for each item)

	Decrease	No Change	Increase
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

PRIOR MEDICAL HISTORY

Have you had any of the following health problems? (please check all that apply)

☐High blood pressure	☐Diabetes or high blood sugar	☐Kidney disease
☐Angina or chest pain	☐Heart attack	☐Liver disease
☐Asthma or wheezing	☐Chronic cough	☐Arthritis
☐TIA or stroke	☐Seizure or epilepsy	☐Bleeding problem
☐Peptic Ulcer Disease (Ulcers)	☐Gastro esophageal Reflux Disease	☐Thyroid Problems

☐Cancer: please specify what type_____

☐Other: please specify _____

_____

_____

_____

SURGERIES

Date (approximate)	Hospital	Type of Operation

REVIEW OF SYSTEMS

Please check all items you feel are applicable to you.

- ☐ Have you had recent unexplained weight loss, fatigue, fever?
- ☐ Do you have difficulty swallowing, sore throat?
- ☐ Double or blurred vision?
- ☐ Do you have shortness of breath?
- ☐ Do you have palpitations (awareness of fast heart)?
- ☐ Do you have chest pain?
- ☐ Abdominal pain?
- ☐ Nausea?
- ☐ Vomiting spells? (other than during pregnancy)
- ☐ Intolerance (e.g. get sick) of a variety of foods?
- ☐ Diarrhea?
- ☐ Urinary retention or difficulty urinating?
- ☐ Urinary frequency or incontinence?
- ☐ Do you have genital pain? (other than during sex)
- ☐ Do you experience pain during intercourse?
- ☐ Do you have back pain or stiffness?
- ☐ Do you have joint pain (knee, elbow, etc.)?
- ☐ Do you have joint swelling?
- ☐ Do you have neck pain or stiffness?
- ☐ Do you have pain in the arms and/or legs?
- ☐ Blindness, pain in eyes, excessive tearing?
- ☐ Fainting spells, loss of consciousness, or blackouts?
- ☐ Do you frequently have dizziness?
- ☐ Do you ringing in ears, hearing loss, or ear pain?
- ☐ Headaches?
- ☐ Seizures or convulsions?
- ☐ Tremors?
- ☐ Muscle weakness?

MEDICATIONS

Indicate the prescription medications you are currently taking. Please tell us the dosage of your pain medications (if known) and number of pills you take (on average) of this medication.

Pain Medication(s)	Other Medication(s) (can attach list)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

Please indicate the names of any medications to which you are allergic.

_____
_____
_____

☐ Yes, I am allergic to dye put into my body (X-ray dye)

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right.

Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
☐ Hospital bed rest		☐	☐	☐
☐ Traction		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Hypnosis		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Nerve block or other injections		☐	☐	☐
☐ TENS		☐	☐	☐
☐ Physical therapy		☐	☐	☐
☐ Exercise		☐	☐	☐
☐ Heat treatment		☐	☐	☐
☐ Ice treatment		☐	☐	☐
☐ Biofeedback		☐	☐	☐
☐ Psychotherapy		☐	☐	☐
☐ Chiropractic		☐	☐	☐
☐ Other		☐	☐	☐

EDUCATION

Your highest educational level achieved:

☐ graduate or professional training (obtained degree)
☐ college graduate (obtained degree)
☐ partial college training
☐ high school graduate
☐ GED or trade-technical school graduate
☐ partial high school (10th grade through partial 12th)

EMPLOYMENT

Your current or former occupation:

☐ skilled trade or clerical (e.g., electrician, truck driver, secretary)_____
☐ semi-skilled or unskilled (e.g., dishwasher, porter, assembler)
☐ business executive or managerial_____
☐ professional_____
☐ homemaker
☐ other_____

Current employment status (please check all that apply):

☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Homemaker
☐ Retired
☐ Student

If you are currently unemployed, indicate how long you have been off work:

☐ 1 - 3 weeks
☐ 1 - 3 months
☐ 4 - 7 months
☐ 8 - 11 months
☐ 12 - 18 months
☐ 19 - 24 months
☐ 25 or more months

LEGAL ISSUES

Please indicate any of the following claims you have filed related to your pain problem:

☐ Workers' compensation
☐ Personal injury/liability (unrelated to work)
☐ Social Security Disability Insurance (SSDI)

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ☐Yes ☐No
If yes, when? _____

Have you ever considered suicide? ☐Yes ☐No

SOCIAL HISTORY

Do you smoke? NO_____ YES_____ How Much? _____
Do you drink any alcohol? NO_____ YES_____ How Often? _____
Do you have any history of substance abuse? NO_____ YES_____ If yes, which kind?
_____
Do you have any history of prescription medication abuse? NO_____ YES_____ If yes, please explain. _____

FAMILY HISTORY

Family history of back pain? NO_____ YES_____ Whom? _____
Family history of migrane headaches? NO_____ YES_____ Whom? _____
Family history of any other medical problems (high blood pressure, diabetes, heart disease, cancer, etc.)? Whom?
_____
_____
_____

FOR OFFICE STAFF ONLY

PHYSICAL EXAM

BP:_____/_____ HT:_____
P:_____ WT:_____
RR:_____ HEART:_____
O2 Sat:_____% LUNGS:_____

STRENGTH
UE: /5
LE: /5
REFLEXES
UE: /4
LE: /4
SENSATION
UE:
LE:

SLR (L)_____ (R)_____
FACET LOAD LUMBAR (L)_____ (R)_____
PATRICK'S (L)_____ (R)_____
SPURLING'S (L)_____ (R)_____
HOFFMAN'S (L)_____ (R)_____
FACET LOAD CERVICAL (L)_____ (R)_____
OTHER:_____
_____
_____

LUM FLEX_____
LUM EXT_____
CERV FLEX_____
CERV EXT_____

DIAGNOSIS

1. _____
2. _____
3. _____

PLAN OF TREATMENT

_____
_____
_____
_____
_____