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)? _____ (#) years _____(#) 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:
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 12 - 18 months
1 - 3 months 19 - 24 months
4 - 7 months 25 or more months
8 - 11 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 SLR (L)_____ (R)_____ LUM FLEX_____
UE: /5 FACET LOAD LUMBAR (L)_____ (R)_____ LUM EXT_____
LE: /5 PATRICK'S (L)_____ (R)_____
REFLEXES SPURLING'S (L)_____ (R)_____ CERV FLEX_____
UE: /4 HOFFMAN'S (L)_____ (R)_____ CERV EXT_____
LE: /4 FACET LOAD CERVICAL (L)_____ (R)_____
SENSATION OTHER:_____
UE: _____
LE: _____
DIAGNOSIS
1. _____
2. _____
3. _____
PLAN OF TREATMENT
_____
_____
_____
_____
_____