GLOWACKI MD INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

COMPREHENSIVE PAIN QUESTIONNAIRE

Complete this form before your first appointment at Glowacki, M.D. 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, etc.).

Name: _____ **Referred by:** _____
(Last, First, Middle)

CHARACTERISTICS OF PAIN

What is the main problem for which you are seeking treatment at Glowacki, M.D.?
(What type of pain? Back, neck, leg, joint, etc.):

_____

_____

_____

PAIN INTENSITY

Please circle your current level of pain.

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

Please explain

_____

_____

_____

PROGRESSION OF PAIN

[ ] Gradual onset
[ ] Rapid onset

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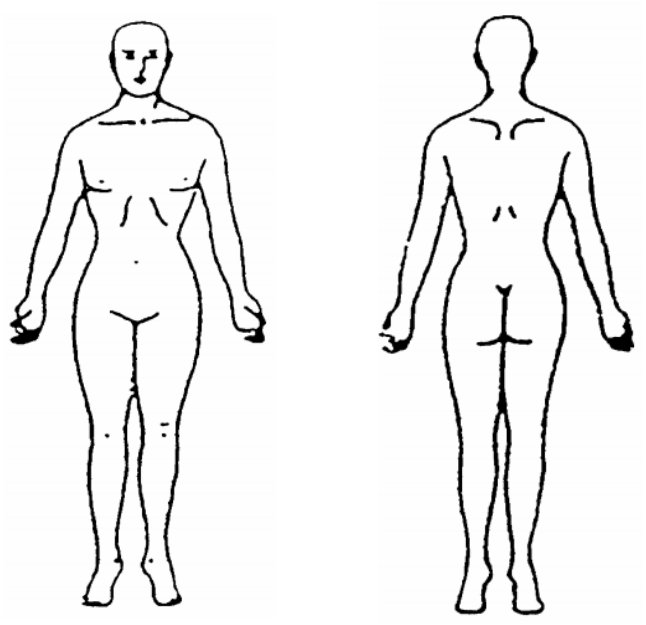
PAIN QUALITY

How would you describe the pain? (Please check all that apply).

[ ] 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 to the left with an "X."

If whole areas are painful, please shade in the painful area.

SLEEP DISTURBANCES

Do you have difficulty falling asleep?	[ ] Yes	[ ] No	Comments: _____
Do you have difficulty remaining asleep?	[ ] Yes	[ ] No	Comments: _____
Are you ever awakened by the pain?	[ ] Yes	[ ] No	Comments: _____

RELIEVING AND AGGREVATING FACTORS

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

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

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PRIOR MEDICAL HISTORY

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

[ ] AIDS/HIV	[ ] Depression	[ ] High Cholesterol
[ ] Acid Reflux (GERD)	[ ] Diabetes or high blood sugar	[ ] Hypertension
[ ] Anemia	[ ] Difficulty Swallowing	[ ] Kidney Disease
[ ] Anxiety Disorder	[ ] Fibromyalgia	[ ] Liver Disease
[ ] Arthritis	[ ] Gout	[ ] Osteoporosis
[ ] Asthma	[ ] Head Trauma/Injury	[ ] TIA or Stroke
[ ] Back Injury	[ ] Headaches	[ ] Substance Abuse
[ ] Bleeding Disorder	[ ] Heart Attack (MI)	[ ] Thyroid Problems
[ ] COPD	[ ] Heart Disease	[ ] Tuberculosis
[ ] Chronic Ear Infections	[ ] Hepatitis	[ ] Ulcers
[ ] Coronary Artery Disease	[ ] Hernia	[ ]

[ ] Cancer (please specify): _____

[ ] Other (please specify): _____

_____

SURGERIES

Date (approx.)	Hospital or Facility	Type of Operation

MEDICATIONS (can attach list)

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

*** PAIN Medication(s)**	Dosage/Amount	*** OTHER Medication(s)**
_____	____/____	_____
_____	____/____	_____
_____	____/____	_____
_____	____/____	_____
_____	____/____	_____

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)

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REVIEW OF SYSTEMS

Please check all items you feel are applicable to you.

[ ] 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 or nausea?
[ ] Vomiting spells? (other than during pregnancy)
[ ] Intolerance 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 have ringing in ears, hearing loss, or ear pain?
[ ] Headaches?
[ ] Seizures or convulsions?
[ ] Tremors?
[ ] Muscle weakness?
[ ] Recent unexplained weight loss, fatigue, fever?
[ ] Difficulty swallowing, sore throat?

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and 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	_____	[ ]	[ ]	[ ]
[ ] Psychotherapy	_____	[ ]	[ ]	[ ]
[ ] Chiropractic	_____	[ ]	[ ]	[ ]
[ ] Other	_____	[ ]	[ ]	[ ]

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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? [ ] Yes [ ] No If yes, how much? _____

Vaporizers or e-cigarettes? [ ] Yes [ ] No If yes, how much? _____

Do you drink any alcohol? [ ] Yes [ ] No If yes, how often? _____

Do you have any history of substance abuse? [ ] Yes [ ] No

If yes, which kind? _____

Do you have any history of prescription medication abuse? [ ] Yes [ ] No

If yes, please explain: _____

FAMILY HISTORY

Family history of back pain? [ ] Yes [ ] No If yes, whom? _____

Family history of migraine headaches? [ ] Yes [ ] No If yes, whom? _____

Family history of any other medical problems (high blood pressure, diabetes, heart disease, cancer, etc.)?

[ ] Yes [ ] No If yes, whom? _____

_____

_____