

# Regional Pain Treatment Medical Center

## Pain Management Questionnaire



Please read these questions **LINE by LINE** and carefully answer them to the best of your ability.

Thank you very much for taking the time to fill out this form! It will help Your Doctor help you!

**Patient Name:** \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_ **Pharmacy Name and Tel #:** \_\_\_\_\_

Insurance: Workers Compensation / Private / Medicare / Accident / HMO

Insurance name: \_\_\_\_\_ Claim#: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title \_\_\_\_\_ Duties \_\_\_\_\_

Do you have pain as a result of the (work/auto) injury? Y / N Date of Accident - Injury(s): \_\_\_\_\_

Referring Doctor(s): \_\_\_\_\_

**Complaints:** Why have you come to see the Doctor

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Current Pains:** \_\_\_\_\_

**Pain Scale:** Please Circle #: Please rate your. 0 = no pain, to 10 = worst pain imaginable

0    1    2    3    4    5    6    7    8    9    10

**Mechanism of Injury:** How did you get hurt ?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Car Accidents:** were you wearing seat belt? \_\_\_\_\_ Did it deploy ? \_\_\_\_\_ Alone in car ? \_\_\_\_\_ Who was at fault? \_\_\_\_\_

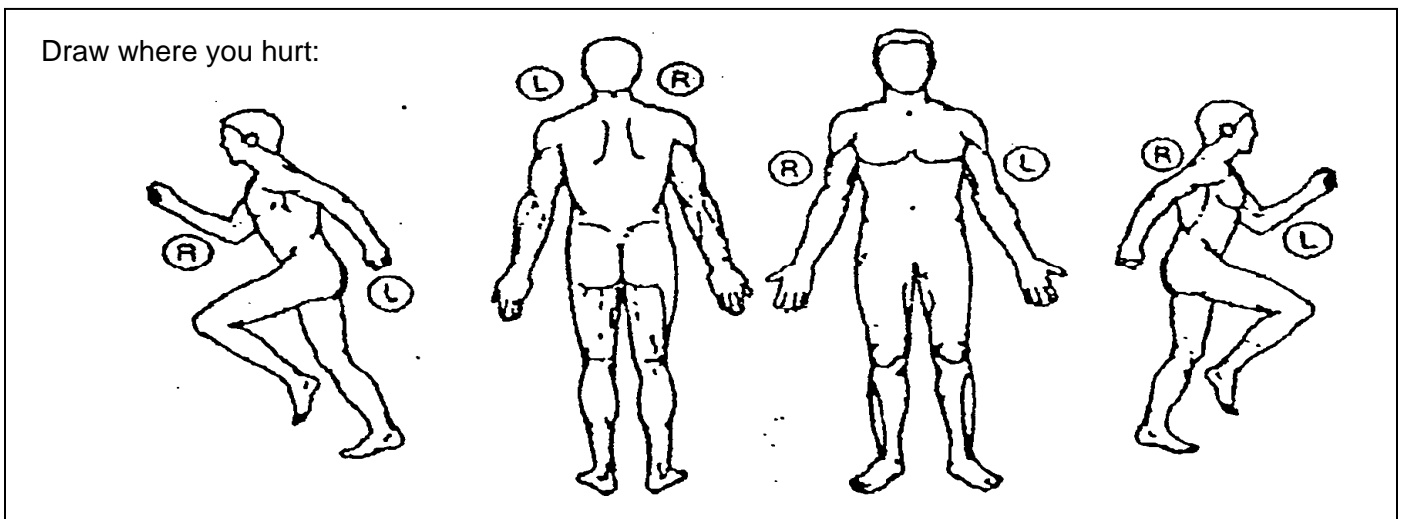
**Work Accident - Injury:** Reported to employer ? \_\_\_\_\_ Accepted by Insurance? \_\_\_\_\_ Disability Payments ? \_\_\_\_\_

**Pain Description:** Please Circle any positive words which best describe your pain?

Aching	Shooting	Dull	Constant	Burning	Stabbing
Tingling	Tight	Radiating	Cramping	Hotness	Sharp
Heavy	Annoying	Numbing	Coldness	Intense	Transient
Severe	Stinging	Soreness	Brief	Unbearable	Excruciating

**Drawing:** Please shade / draw in the areas where you have pain: This is very important !

Is there any numbness / tingling / weakness / swelling? ( ) Yes ( ) No



What makes the pain **Worse**? (Circle appropriate activity) ? Describe activities which aggravate your pain:

Sitting	Bending	Lifting	Driving	Rising from a chair	Turning	Twisting
Walking	Running	Carrying	Stress	Sexual Relations	Repetitive activity	
Standing	Reaching	Lying Down	Other: _____			

# Regional Pain Treatment Medical Center

## Pain Management Questionnaire



What makes your pain **Better**? Lying down ( Face lying, Back lying, Side-lying)  
 Stretching                      Activity                      Ice                      Heat                      Massage                      Injections  
 Sitting                      Exercise                      Sleep                      Medication                      Other: \_\_\_\_\_

**Treatments:** What have you had ? \_\_\_\_\_

Are you: ( ) Improved ( ) Worsened ( ) Same - why ?:  
**Physical Therapy or Chiropractic** ? \_\_\_\_\_ Received When? \_\_\_\_\_ Helping? \_\_\_\_\_ By who? \_\_\_\_\_

Any falling? \_\_\_\_\_ Any giving way of Limb or joints? \_\_\_\_\_ Which? \_\_\_\_\_

Any new Bowel or Bladder Incontinence problems? ( ) Yes ( ) No Any old Incontinence ? \_\_\_\_\_

Sleep Disturbance ? \_\_\_\_\_ Hours of sleep at night: \_\_\_\_\_  
 Depressed ? \_\_\_\_\_ Stressed ? \_\_\_\_\_ Why ? \_\_\_\_\_ Suicide Thoughts ? \_\_\_\_\_  
 Are you Gaining weight ? \_\_\_\_\_ How Pounds since Injury ? \_\_\_\_\_

**Females:** Do think you can be pregnant? Y/ N please notify staff !

**Surgical History** Type and year: \_\_\_\_\_

**Past Injections:** \_\_\_\_\_

**Medical History:** Circle any positives: ( ) HEALTHY ( ) Chronic Pain ( ) Opioid Dependence

Anemia	Birth Defect	Heart Disease	Migraines	Sexually Transmitted Dz
Anxiety	COPD	Hepatitis/ Jaundice	Mental Disorder	Stroke /Paralysis
Arthritis	Cholelithiasis	Hypertension	Osteoporosis	Skin Disease
Angina - MI	Diabetes I - II	Hernia	Obesity	Thyroid Disease
AIDS-HIV	Epilepsy/Seizures	HyperCholesterol	P. Vascular Dz	Tuberculosis
Asthma /Fracture	Infections	Pneumonia	Ulcer _____	Spinal Injury
Bleeding Disorder	GI Disorder	Kidney Failure	Pancreatitis	Rheumatic Fever
Blood Clots/ DVT	Sleep Disorder	Cancer of _____		
Other _____				

<b>Medications:</b> Please List all medications:			What Opioid Meds do you take?		
Name	Dose	How Often?	Name	Dose	How Often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you taking **Coumadin**? ( ) Yes ( ) No **Plavix** ? Other Blood thinner? \_\_\_\_\_

**ALLERGIES to medications** ? \_\_\_\_\_

**Sensitive to medications** ? \_\_\_\_\_ Phobias: \_\_\_\_\_

**Systems Review :** Circle if you have problems with any of the following areas at this time.

**Head:** Headaches Seizures / **Eyes** Redness Blurry Vision Double vision Eye Pain /

**Ears:** Ringing/Buzzing, Loss of Hearing, Pain / **Throat:** Hoarseness, Drainage **Nose** Bleeding Drainage Allergies

**Kidney/Bladder/Genitalia** Incontinence, Frequency/Urgency, Blood in urine/ **Abdomen** Cramping Pain Ulcer Nausea

**Lungs/Breathing** Pain with deep breath Persistent Cough Blood Wheezing / Shortness of Breath Infections

**Heart/Circulation** Murmur Chest Pain Heart failure Leg Swelling

**Bones/Joints:** Muscle Weakness Joint Stiffness Pain Swelling Grinding/ Popping

**Emotional/ Psychological** Depression Anxiety Stress at Work Thoughts of Suicide Thoughts/Acts of Violence Loss of Appetite

Do you currently have an **infection** of any kind ? (Y) (N) please notify staff ! Where? \_\_\_\_\_

Comments: \_\_\_\_\_

**Patient Declaration:** The information given in this history questionnaire was provided by myself with or without an interpreter and is true. I understand and authorize the release of my medical records to my insurer, employer, workers compensation carrier and any other party involved , as is necessary to process this claim.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_