PAIN CONSULTANTS of ARIZONA

Comprehensive Pain Questionnaire

Complete this form before your first appointment at *Pain Consultants of Arizona*. 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 _____ Date _____

Age: _____ Height: _____ Weight: _____

Would you like a clinical summary of today's visit? ☐ No ☐ Yes

CHARACTERISTICS OF PAIN (Chief Complaint).

What is the main problem for which you are seeking treatment at Pain Consultants of Arizona?

_____

_____

HISTORY OF PRESENT ILLNESS

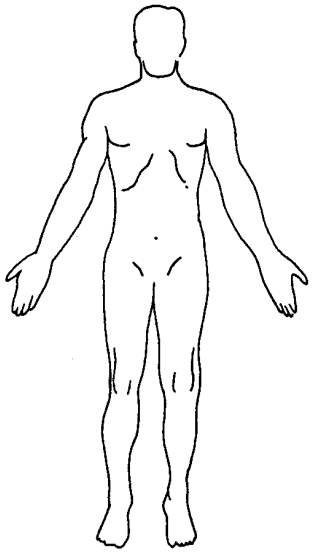
Pain Location

Please describe the location(s) of your pain:

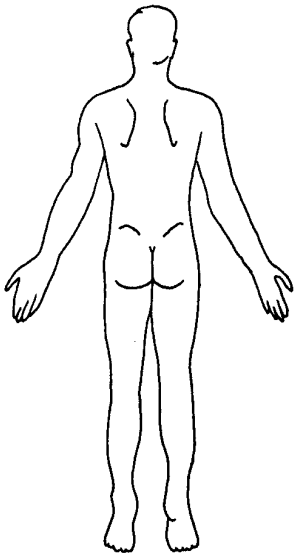
_____

_____.

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.



Front



Back

Onset of Pain (Cause)

How did your current pain start?

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

Progression of Pain

☐ Acute (quick/severe) ☐ Gradual (slow)
☐ Sudden (unexpected) ☐ Variable (intermittent)

Pain Rating

VAS – Visual Analog Scale

	0	1	2	3	4	5	6	7	8	9	10
Current Pain Level	☺										☹
Minimum Pain Level	☺										☹
Maximum Pain Level	☺										☹

Pain Duration

How long have you had your current pain problem(s)?

_____weeks _____months _____ years

Frequency / Timing of Pain

How often do you have your pain? (please check one)

- ☐ Constantly (100% of the time)
- ☐ Nearly constantly (60% to 95% of the time)
- ☐ Intermittently (30% to 60% of the time)
- ☐ Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst? (please check one)

☐Morning ☐Afternoon ☐Evening ☐Night ☐No typical pattern

Activities and Your Pain

Place a check mark next to the activities that you have avoided or limited during the past month because of pain:

- ☐ Going to work
- ☐ Performing household chores
- ☐ Doing yard work or shopping
- ☐ Socializing with friends
- ☐ Participating in recreation
- ☐ Having sexual relations
- ☐ Exercise
- ☐ Sitting
- ☐ Standing
- ☐ Walking

Associated Symptoms

☐ "pins and needles" ☐numbness ☐tingling ☐weakness

Pain Quality

How would you describe the pain?

☐ burning ☐ cutting ☐ other ☐ sharp ☐ throbbing

☐ cramping ☐ dull, aching ☐ pressure ☐ shooting

Relieving and Aggravating 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	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

Attempted 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
☐ Bed rest		☐	☐	☐
☐ Traction		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Hypnosis		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Nerve block or other injections		☐	☐	☐
☐ TENS		☐	☐	☐
☐ Physical therapy		☐	☐	☐
☐ Exercise		☐	☐	☐
☐ Heat		☐	☐	☐
☐ Ice		☐	☐	☐
☐ Biofeedback		☐	☐	☐
☐ Psychotherapy		☐	☐	☐
☐ Chiropractic		☐	☐	☐
☐ Other		☐	☐	☐

Effect on Sleep

☐ No effect ☐ Pain makes it difficult to fall asleep ☐ Pain makes it difficult to stay asleep

Effect on Bowel and Bladder Control

☐ No effect
☐ Loss of bladder control
☐ Loss of bowel control

Assisting Device

Devices used to assist ambulation

☐ Cane ☐ Walker ☐ Wheelchair ☐ None

PAST MEDICAL HISTORY

Medical

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

☐ Angina or chest pain ☐ Chronic cough ☐ Kidney disease ☐ Seizure or epilepsy
☐ Arthritis ☐ Diabetes or high blood sugar ☐ Liver disease ☐ Thyroid Disease
☐ Asthma or wheezing ☐ Heart attack ☐ Peptic Ulcer ☐ TIA or stroke
☐ Bleeding problem ☐ High blood pressure ☐ Reflux (GERD)
☐ Cancer: please specify what type_____
☐ Other: please specify _____

Surgeries

Date (approximate)	Hospital	Type of Operation

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")

MEDICATIONS

Please list any medication that you are currently taking: (list ALL medications)

_____

_____

Please list any pain medication that you have tried in the past:

_____

_____

REVIEW OF SYSTEMS

Please check all items you feel are applicable to you.

General:
☐ Chills?
☐ Fatigue?
☐ Fever? ☐ Daily ☐ Every few days ☐ High ☐ Low ☐ Recurrent ☐ Weekly

☐ Night sweats?
☐ Tiredness?
☐ Weight change? ☐ Gain? ☐ Loss?

Skin:
☐ Do you have itching?
☐ Do you have rashes?

HEENT:
☐ Change in Vision? _____
☐ Ringing in the ears?
☐ Vertigo?
☐ Seasonal allergies?

Respiratory:
☐ Difficulty Breathing?

Cardiovascular:
☐ Chest pain?
☐ Palpitations (awareness of fast heart)?

GI:
☐ Abdominal pain?
☐ Constipation?
☐ Diarrhea?

Musculoskeletal:
☐ Pain in joints?
☐ Stiffness in joints?
☐ Swelling in joints?

Neurological:
☐ Dizziness
☐ Fainting spells?
☐ Headaches?
☐ Stool incontinence?
☐ Urine incontinence?
☐ Numbness
☐ Trouble walking?
☐ Unsteadiness?
☐ Weakness?

Psychiatric:
☐ Anxiety?
☐ Depression?
☐ Insomnia?
☐ Memory loss?
☐ Suicidal ideation?

Hematology:
☐ Abnormal bleeding?
☐ Blood clots?
☐ Bruise easily?

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

GENERAL FAMILY ILLNESS

Please check any health problems that are known to run in your family:

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

☐ Cancer: please specify what type_____

☐ Other: please specify _____

SOCIAL HISTORY

Marital Status

☐ Divorced
☐ Engaged
☐ Married living w/ spouse
☐ Remarried
☐ Separated
☐ Single
☐ Spouse Deceased
☐ Significant other Deceased

Living arrangements

☐ living alone
☐ living with friends
☐ living with children
☐ living with spouse/partner
☐ living with spouse/partner and children
☐ living with other

Employment

Your current or former occupation:

_____

_____

Current employment status (please check all that apply):

☐ Employed full-time
☐ Employed part-time
☐ Student
☐ Unemployed or working part time, because of pain
☐ Unemployed
☐ Retired
☐ Homemaker

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	

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)
☐ Other insurance
☐ None

Substance Abuse

Do you have a history of:

Tobacco use?	☐ Yes-currently	☐ Yes-in the past	☐ Never
Alcoholism?	☐ Yes-currently	☐ Yes-in the past	☐ Never
Illicit (illegal) drug abuse?	☐ Yes-currently	☐ Yes-in the past	☐ Never

Have you ever been in a detoxification program for drug abuse? ☐ Yes ☐ No