

Pain Questionnaire

Referring Physician: _____ Primary Care Provider: _____

1. My current pain problem began (date): _____
2. My current pain problem developed:

<input type="checkbox"/> Gradually over time	<input type="checkbox"/> Suddenly
<input type="checkbox"/> On the job injury: _____	<input type="checkbox"/> Motor vehicle accident: _____
<input type="checkbox"/> Other: _____	
3. I have had similar pain problems that began: _____
4. My pain is:

<input type="checkbox"/> 100% Neck or Back Pain	<input type="checkbox"/> 100% Arm/Shoulder or Leg/ Buttock Pain
<input type="checkbox"/> 50% Neck or Back Pain, 50% Arm/Shoulder or Leg/ Buttock Pain	
<input type="checkbox"/> 75% Neck or Back Pain, 25% Arm/Shoulder or Leg/ Buttock Pain	
<input type="checkbox"/> 25% Neck or Back Pain, 75% Arm/Shoulder or Leg/ Buttock Pain	
5. My pain is best described as (check all that apply):

<input type="checkbox"/> Dull	<input type="checkbox"/> Aching	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Toothache
<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Shooting	<input type="checkbox"/> Electrical	
6. My pain is worse with (check all that apply):

<input type="checkbox"/> Bending forward	<input type="checkbox"/> Bending backward
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing
<input type="checkbox"/> Walking	<input type="checkbox"/> Laying down
<input type="checkbox"/> Looking up	<input type="checkbox"/> Looking down
<input type="checkbox"/> Turning left	<input type="checkbox"/> Turning right
<input type="checkbox"/> Coughing / sneezing	<input type="checkbox"/> Reaching / lifting
<input type="checkbox"/> Pushing / pulling	
7. My pain is better with:

<input type="checkbox"/> Lying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Changing positions
<input type="checkbox"/> Therapy	<input type="checkbox"/> Pain meds	<input type="checkbox"/> Ice	<input type="checkbox"/> Heat
<input type="checkbox"/> Nothing			
8. I have numbness (tingling, thickness, pins and needles, etc.):

<input type="checkbox"/> All the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	If yes, where? _____
---------------------------------------	------------------------------------	--------------------------------	----------------------
9. I have weakness:

<input type="checkbox"/> All the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
If yes, when and where? _____		
10. I have had the following tests for my current problem (Check all that apply)

<input type="checkbox"/> X-rays	<input type="checkbox"/> Cat scan (CT)	<input type="checkbox"/> CT/Myelogram
<input type="checkbox"/> MRI	<input type="checkbox"/> EMG	<input type="checkbox"/> Bone/SPECT scan
<input type="checkbox"/> Diagnostic Spinal Injections (e.g. nerve block, facet/sacroiliac joint block, discogram)		
11. I have tried the following treatments for my pain (Check all that apply and circle those that helped):

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Traction	<input type="checkbox"/> Home/gym exercises	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Manipulation (e.g. manual therapy, chiropractic)	<input type="checkbox"/> Spinal Injections	<input type="checkbox"/> Spinal Surgery		
12. I have tried the following medications for my pain (Check all that apply and circle those that helped):

<input type="checkbox"/> Anti-inflammatories (eg. Motrin, Naproxen)	<input type="checkbox"/> Muscle relaxers (e.g. Soma, Flexeril)
<input type="checkbox"/> Anti seizure drugs (e.g. neurontin, topamax)	<input type="checkbox"/> Narcotics
<input type="checkbox"/> Anti-depressants (e.g. Paxil, Zoloft)	