SportsMED
Center For Spine & Neuro

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PAIN QUESTIONNAIRE

DATE: _____

ACCOUNT: _____

PATIENT NAME: _____ DOB: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN _____

Occupation _____ Is this a job related injury? ☐ YES ☐ NO

Are you still working? ☐ YES ☐ NO Last day on the job? _____

How did your pain start? _____ Do you see another physician for this? ☐ YES ☐ NO

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting ☐ Fall ☐ Bending ☐ Pulling ☐ Injured at Work ☐ Auto Accident ☐ Hit from Behind ☐ Sports

When did your present pain start? _____ Have you had similar pain? _____ Years _____ Months _____ Weeks

Do you take blood thinners? ☐ YES ☐ NO Are you diabetic? ☐ YES ☐ NO

☐ PLAVIX ☐ COUMADIN ☐ PRADAXA ☐ ASPIRIN ☐ FISH OIL Are you claustrophobic? ☐ YES ☐ NO

☐ VITAMIN E ☐ XARELTO ☐ ANTI-INFLAMMATORIES Do you have a pacemaker, defibrillator, pain pump

☐ OTHER _____ or metal in your body? ☐ YES ☐ NO

Allergic to: ☐ Iodine ☐ Shellfish ☐ X-ray dye ☐ Steroids Do you have bladder incontinence? ☐ YES ☐ NO

Do you use nicotine? ☐ YES ☐ NO If yes, how much do you use? _____

Do you use alcohol? ☐ YES ☐ NO If yes, how much do you use? ☐ Daily ☐ Weekly ☐ Monthly

Have you had any of these diagnostic studies for your present pain?

DIAGNOSTIC STUDY	NO	YES	DATE	LOCATION
Diagnostic X-rays				
CT Scan				
Electromyogram (EMG)				
Discogram				
MRI				

Have you had any of the following treatments for your present pain? ☐ **I have not started any treatment.**

TREATMENT	NO	YES	DATE	LOCATION
Physical Therapy				
Home Exercises				
Chiropractic				
Massage				
Brace				
Accupuncture				

Have you had any of the following injections for you pain? If yes, please request records to be sent to our office.

	NO	YES	DATE	LOCATION
Joint, Local, or Trigger Point Injections				
Epidural Steroid Injection				
Facet Joint Injection				

Have you had surgery for this problem? ☐ YES ☐ NO If yes, please request records to be sent to our office.

Have you had any spine surgeries? ☐ YES ☐ NO Number of times: _____ Surgeon: _____ Dates: _____

List medications you are taking now or have taken for this problem: _____

PATIENT NAME: _____ Date: _____

Please check all that describe your pain.

☐ Burning ☐ Sharp/Stabbing ☐ Tingling ☐ Aching ☐ Throbbing ☐ Shooting ☐ Numbness ☐ Pressure ☐ Pulling/Tearing ☐ Cramping

☐ Other _____

Please check all the appropriate responses in each category to complete the phrase

My pain ☐ interrupts my sleep ☐ is constant ☐ comes and goes

My pain is **worse** ☐ during the day ☐ at night ☐ in the morning ☐ in the afternoon

My pain is **worse** when ☐ nothing makes my pain worse

☐ Walking ☐ Running ☐ Standing ☐ Standing ☐ Sitting ☐ Lifting ☐ Driving ☐ Exercise (during) ☐ Exercise (after) ☐ Bending forward
☐ Bending backward ☐ Coughing/Sneezing ☐ Overhead activity ☐ Medication ☐ Applying heat/ice ☐ Frequently changing positions

☐ Sports _____ ☐ Other _____

My pain is **better** when ☐ nothing makes my pain better

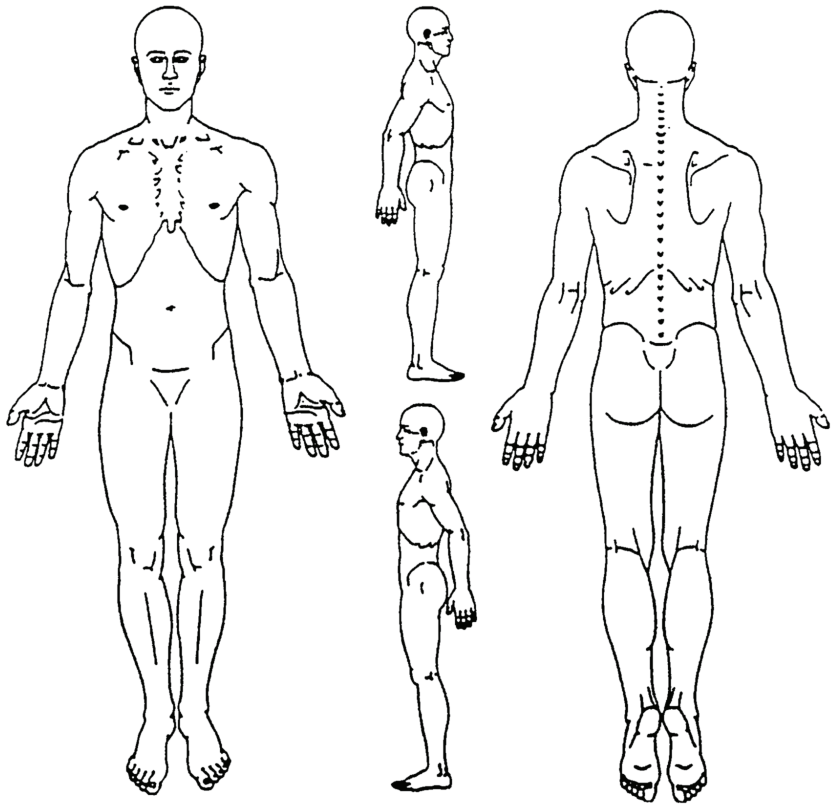
☐ Walking ☐ Running ☐ Standing ☐ Standing ☐ Sitting ☐ Lifting ☐ Driving ☐ Exercise (during) ☐ Exercise (after) ☐ Bending forward
☐ Bending backward ☐ Coughing/Sneezing ☐ Overhead activity ☐ Medication ☐ Applying heat/ice ☐ Frequently changing positions

☐ Sports _____ ☐ Other _____

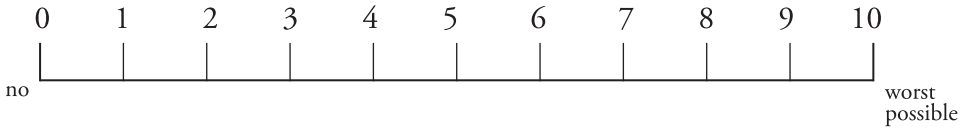
Where is your pain now?

Mark the areas on your body where you feel the sensations described below using the correct symbol.
Mark the areas of radiation. Include all affected areas.

△△△ **Aching** === **Numbness** OOO **PIns/Needles** XXX **Burning** /// **Stabbing**



Visual Analog Scale (VAS)



PAIN SCALE
0 (NO PAIN) **10 (SEVERE ENOUGH TO PASS OUT)**
What number would you give your pain on **average**?
What number would you give your pain **today**?
What number would you give your pain at its **worst**?

PAIN SCALE
_____% Of relief

W _____

H _____

BP _____

Pulse _____

Signature: _____ Date: _____

Physician reviewed : _____ Date: _____ Signature: _____