COMPREHENSIVE REHABILITATION PAIN QUESTIONNAIRE

Please complete and bring to appointment

Name_____ Date of Visit_____

Address_____ Referred by_____

_____ Statement of Problem: _____

Home Phone: _____ Date of Injury/onset of condition: _____

Date of birth: _____ Age_____ SSN_____

Circumstances of injury/onset: _____

_____

_____

Location at time of injury/onset: _____Time of event: _____

What increases your symptoms? (Mark each one that applies)

_____ sitting _____ standing _____ walking _____ bending _____ lifting

_____ twisting _____ stooping _____ coughing _____ sneezing _____ reclining

_____ reaching _____ gripping _____ driving _____ pinching _____ squatting

_____ climbing

Other (please list) _____

What time of day is your pain worst? _____

What time of day is your pain least? _____

What percentage of your pain is arm or leg pain? _____ What percentage of your pain is neck or back pain? _____

What decreases your symptoms?

_____ _____

_____ _____

_____ _____

Please list 3 goals you would like to achieve as a result of medical treatment.

_____

_____

_____

Which daily activities are affected by your current pain condition?

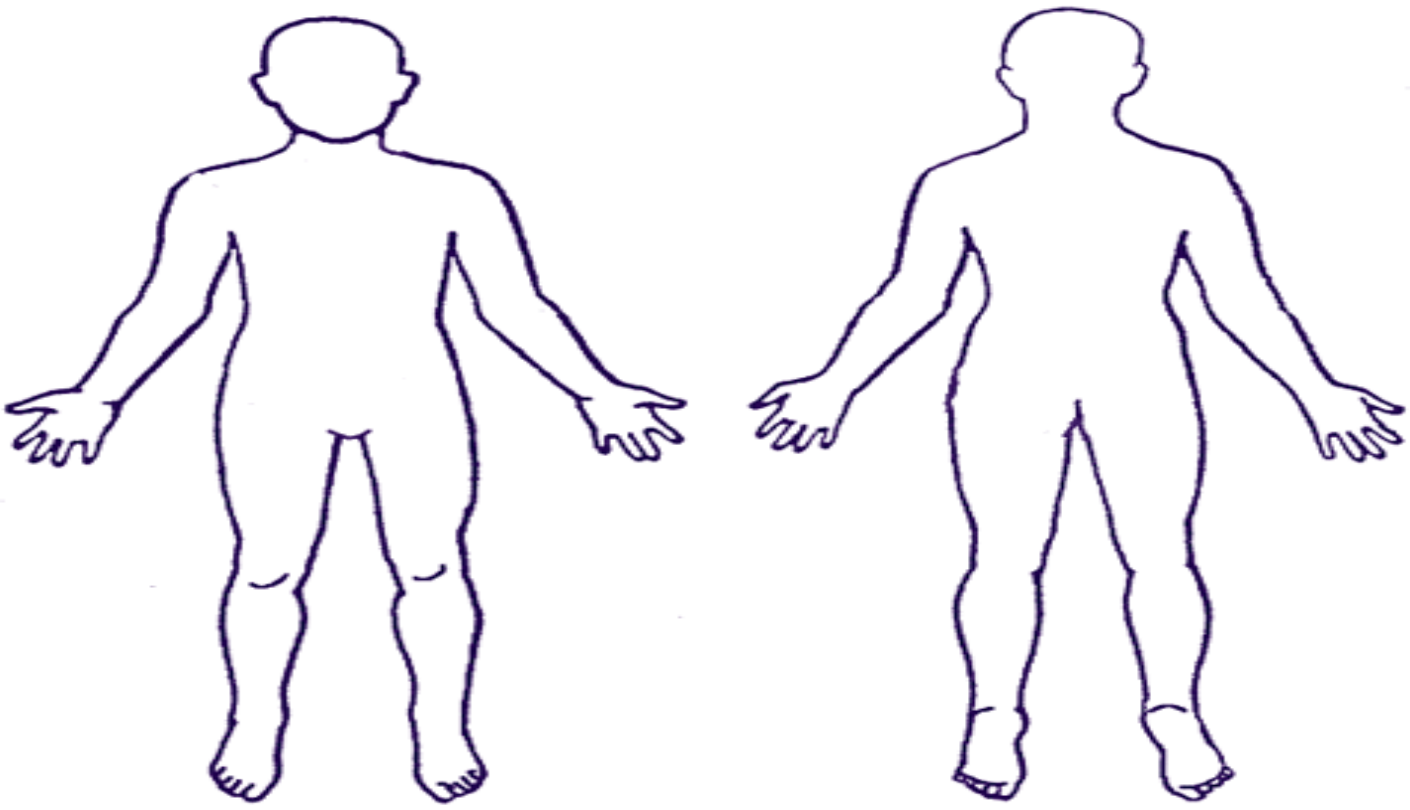
_____

_____

Pain Diagram

Mark the areas on your body where you feel your pain.
Include all affected areas. Use the appropriate symbols indicated below.

Ache >>>	Numbness ===	Pins&Needles . . .	Burning XXX	Stabbing / / /
>>>	===	. . .	XXX	/ / /
>>>	===	. . .	XXX	/ / /



Is your pain constant? Yes / No If yes, has it been constant for the last year? Yes / No

If no, how many days per week do you have pain? _____ How many hours per day? _____

Please place an "X"" on the line below to indicate the level of your pain.

Today: None_____ 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 severe / worst imaginable

Least: None_____ 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 severe / worst imaginable

Worst: None_____ 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 severe / worst imaginable

How would you describe the overall severity of your pain?

_____ Mild nuisance pain

_____ Moderate – I am having difficulty dealing with it.

_____ Mild to moderate, but I can live with it.

_____ Severe – it is ruining my quality of life

Have you ever been to a pain management clinic in the past for your complaint? Yes / No
If yes, when where and who was your physician?

Please circle all of the previous medications that you have tried:

Medication	Discontinued Reason		Discontinued Reason
Ibuprofen	_____	Cymbalta	_____
Naprosyn	_____	Effexor	_____
Aspirin	_____	Lexapro	_____
Tylenol	_____	Zoloft	_____
Celebrex	_____	Paxil	_____
Bextra	_____	Prozac	_____
Mobic	_____	Lidoderm Patch	_____
Arthrotec	_____	Ultram/Ultracet/Ultram ER	_____
Relafen	_____	Tylenol #3/Tylenol #4	_____
Skelaxin	_____	Darvocet/Darvon	_____
Flexeril	_____	Percocet/Percodan	_____
Soma	_____	Lortab/Lorcet/Vicodin/Vicoprofen	_____
Zanaflex	_____	Morphine	_____
Robaxin	_____	Dilaudid	_____
Valium	_____	Duragesic Patch	_____
Xanax	_____	Oxycontin	_____
Neurontin	_____	Demerol	_____
Tegretol	_____	Actiq	_____
Zonegran	_____	Fentora	_____
Lyrica	_____	Opana	_____
Elavil	_____	MS Contin	_____
Pamelor	_____	Kadian	_____
		MSIR	_____
Avinza	_____		
Oramorph	_____	Voltaren gel	_____
Wellbutrin	_____		
Flector Patches	_____		

Please circle all of the previous treatments:

Treatment/Procedure	Limited Relief	Lasting Relief
PT/OT	Yes / No	Yes / No
Orthotic Device	Yes / No	Yes / No
TENS Unit	Yes / No	Yes / No
Osteopathic Manipulation	Yes / No	Yes / No
Epidural Injection	Yes / No	Yes / No
Facet Block	Yes / No	Yes / No
Nerve Block	Yes / No	Yes / No
Sacroiliac Joint Injection	Yes / No	Yes / No
Trigger Point Injection	Yes / No	Yes / No
Joint Injection	Yes / No	Yes / No
Acupuncture	Yes / No	Yes / No
Chiropractor	Yes / No	Yes / No
Stimulator/Pump	Yes / No	Yes / No
Massage Therapy	Yes/ No	Yes/ No

Personal / Medical History

Do you have a primary care provider (family physician)? Yes / No If yes, who? _____

List past and current medical and/or psychological problems (please describe and give approximate dates of onset, use a separate sheet if necessary).

_____

_____

_____

_____

_____

Surgeries: _____

_____

Current Medications (please list)

MEDICATION	REASON	DOSE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any other medications on a separate sheet.

Medication allergies: _____

Please tell us about yourself

What is your highest level of education completed? _____:
Are you: ____Single ____Married _____Separated _____Divorced _____Widowed

Do you have children? Yes / No If yes, how old are they? _____

What is your occupation? _____ Employer: _____

Do you use tobacco? Yes / No If yes, do you smoke cigarettes?_____How many per day? _____How many years? _____
Do you smoke cigars or a pipe? _____How many per day? _____ How many years? _____
Do you chew tobacco? _____ How many cans per week? _____ How many years?_____

Are you a former smoker / tobacco user? Yes / No If yes, at what age did you quit?_____

Do you use alcohol? Yes / No If yes, how many alcoholic beverages do you drink in a usual week? _____
If no, have you ever used alcohol? Yes / No

Do you currently use recreational drugs? Yes / No
If yes, what type and how much? _____

Have you had abuse problems with recreational drugs in the past? Yes / No
If yes, please describe: _____

Have you had abuse problems with prescription medications in the past? Yes / No
If yes, please describe: _____

Are the any recreational drug problems or problems with prescription medications in your household at the present time?
If yes, please describe: _____

Please circle the appropriate diseases with regards to your family history:

Mother	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack
Father	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack
Siblings	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack
Sons/Daughters	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack
Aunts/Uncles	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack
Grandparents	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack

Please circle any problems that you have from the list below:

Abdomen
Vomiting
Diarrhea
Constipation
Bloody Stools
Heartburn

Genitourinary
Pain with urination
Inability to urinate
Incontinence
Bloody urination
Decreased desire for sex

Psychiatric
Anxiety
Depression
Memory Loss
Suicidal Ideation
Inability to sleep

General
Fever
Chills
Fatigue
Sweats

Lungs
Cough
Shortness of Breath
Cough up blood
Sleep Apnea

Heart
Chest pain
Irregular Heart beat
Heart Murmur

Ear/Nose/Throat
Ringing in Ears
Loss of hearing
Nose Bleeds
Sore Throat
Hoarseness

Neurological
Fainting spells
Weakness
Dizziness
Headaches
Tremors

Endocrine
Weight gain
Weight loss
Excessive Thirst
Cold Intolerance
Heat Intolerance
Thyroid Disease

Eyes
Blurry Vision
Double Vision
Irritation
Discharge

Skin
Rashes
Coldness of hands/feet
Dry Skin
Easy Bruising

Musculoskeletal
Joint pain
Joint swelling
Muscle Cramps

Past Medical History

Depression_____
Chicken Pox _____
Arthritis_____
Mumps/Measles _____
Cancer_____
Hepatitis_____
Skin Disease_____
Polio_____
AIDS/HIV_____
Epilepsy_____
Blood Transfusion _____
Infectious Mono_____
STD_____

Are you currently pregnant or may be pregnant? _____

Please circle your daily activities on a typical day.

Walking: greater than 20mins or less than 20mins.
Drive
Cook/Dishes
Vacuuming, mopping, sweeping floors
Dress Children/Spouse

Stairs: Go up/down at least one flight of steps unassisted.
Grocery shop unassisted/put away groceries
Laundry
Dress Self
Bathe unassisted

_____

_____

_____