Pain Assessment Questionnaire

I. PATIENT INFORMATION

NAME:___________________________________________________________________________________

REFERRING PHYSICIAN:_____________________________________________________________________

PRIMARY CARE PHYSICIAN:_________________________________________________________________

II. CHIEF COMPLAINT (CHARACTERISTICS OF PAIN)

WHAT IS THE MAIN COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT?
_____________________________________________________________________________________

DESCRIBE THE LOCATION OF YOUR PAIN:_____________________________________________________

WHEN DID THE PAIN BEGIN?_________________________________________________________________

DID THE PAIN BEGIN SUDDENLY OR GRADUALLY?___________________________________________

HAS THE PAIN BEEN GETTING BETTER OR WORSE?___________________________________________

IS THE PAIN CONSTANT, OR DOES IT COME AND GO?________________________________________

DOES THE PAIN RADIATE?________________ IF SO, WHERE?____________________________________

WHAT DO YOU FEEL CAUSED YOUR PAIN?____________________________________________________

ON A SCALE OF 0-10 (0 = NO PAIN AND 10 = WORST PAIN) HOW WOULD YOU RATE YOUR PAIN?
AT IT’S BEST_____________ AT IT’S WORST ____________ TODAY __________

PLEASE CIRCLE THE WORDS WHICH BEST DESCRIBE THE CHARACTER OF YOUR PAIN:

ACHING  THROBBING  SHARP  CRAMPING  SHOOTING  STABBING
BURNING  POUNDING  ANNOYING  MISERABLE  TINGLING  UNBEARABLE
AGONIZING  TROUBLESOME  RIPPING  TEARING  DULL  NUMBNESS
WEAKNESS  SPASMS  COLDNESS

PLEASE CIRCLE THE EFFECTS THAT YOUR PAIN HAS HAD ON YOU:

NERVOUS  DEPRESSED  ANXIOUS  APPETITE PROBLEMS  WEIGHT GAIN
IRRITATED  WEIGHT LOSS  ANGRY  SLEEP DISTURBANCES

PLEASE LIST ACTIVITIES OR POSITIONS WHICH GIVE YOU SOME DEGREE OF PAIN RELIEF:
_____________________________________________________________________________________

PLEASE LIST ACTIVITIES OR POSITIONS WHICH AGGRAVATE YOUR PAIN:___________________________
_____________________________________________________________________________________

PLEASE TRY TO ANSWER ALL QUESTIONS ON THESE SHEETS.
III  MEDICATIONS

PLEASE LIST ALL MEDICATIONS WHICH YOU ARE CURRENTLY TAKING (INCLUDE QUANTITY AND FREQUENCY):
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

DO YOU HAVE ANY ALLERGIES? IF SO, LIST:
__________________________________________________________________________________________
__________________________________________________________________________________________

PLEASE LIST ANY MEDICATIONS YOU HAVE TRIED TO CONTROL YOUR PAIN:
__________________________________________________________________________________________
__________________________________________________________________________________________

IV  PAST MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS? (PLEASE CIRCLE)

- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- SHORTNESS OF BREATH
- ANGINA/ CHEST PAIN
- ULCER DISEASE
- LIVER DISEASE
- ARTHRITIS
- ASTHMA
- HEART ATTACK
- DIABETES (SUGAR)
- SEIZURES
- CANCER
- BLEEDING DISORDER
- STROKE
- KIDNEY DISEASE
- BRONCHITIS
- IRRITABLE BOWEL
- THYROID DISEASE
- DEPRESSION
- GLAUCOMA
- ANXIETY
- HEADACHES
- ALCOHOLISM/SUBSTANCE ABUSE
- OTHERS, EXPLAIN: ______________________________________________________________

PAST SURGERIES: _______________________________________________________________________

V  EMPLOYMENT HISTORY

IS YOUR PAIN DUE TO A WORK RELATED INJURY? YES____ NO____
CURRENTLY EMPLOYED? YES____ NO____ IF YES, WHERE? ________________________________
FULL TIME _____ PART TIME _____ RESTRICTIONS? _______________________________________
HOW LONG HAVE YOU WORKED AT THE ABOVE EMPLOYER? ______________________________
YOUR OCCUPATION ______________________________ DO YOU ENJOY YOUR WORK? YES____ NO____
IF NOT EMPLOYED, ARE YOU CURRENTLY DISABLED_____ RETIRED_____ STUDENT_____ 
WHAT WAS YOUR LAST DAY WORKED? _______________________________________
HAVE YOU TRIED TO RETURN TO WORK? YES____ NO____
WOULD YOU RETURN TO WORK IF YOU HAD NO PAIN PROBLEM? YES____ NO____
IS YOUR POSITION BEING HELD OPEN FOR YOU? YES____ NO____
DO YOU RECEIVE COMPENSATION OR DISABILITY PAYMENTS? YES____ NO____
ARE YOU IN THE PROCESS OF APPLYING FOR WORKER’S COMPENSATION? YES_____ NO_____ 
SOCIAL SECURITY DISABILITY? YES_____ NO_____ 
ARE YOU INVOLVED IN A LAW SUIT CONCERNING YOUR PAIN? YES____ NO____
IF YES, IS IT ONGOING OR SETTLED? ____________________________________________
VI SOCIAL HISTORY

DATE OF BIRTH: ____________________________________
MARITAL STATUS:   SINGLE _____    MARRIED _____    DIVORCED _____    WIDOWED _____   
SMOKE _____    HOW MUCH? _______________     ALCOHOL ______
HEIGHT _______________          WEIGH T __________________

VII REVIEW OF SYSTEMS

Please circle if you have RECENTLY (in the past 30 days) experienced any of the following:

General, Constitutional: Recent weight loss, recent weight gain, fever, chills, night sweats, insomnia

Eyes, Ears, Nose and Throat: Double vision, blurry vision, glaucoma, hearing loss, hearing difficulty, ringing in the ears, earache, drainage, dry mouth, sore throat, thrush, altered smell

Cardiovascular: Chest pain, palpitations, swelling in the extremities, varicose veins, leg cramping

Respiratory: Cough, shortness of breath, wheezing, asthma, sputum, coughing up blood, COPD, tuberculosis

Gastrointestinal: Abdominal pain, heartburn, bloody stool, bowel incontinence, constipation, diarrhea, nausea, Vomiting, swallowing difficulties, rectal bleeding, yellow eyes or skin

Genitourinary: Frequent urination, burning with urination, urinary urgency, urinary incontinence, blood in Urine

Musculoskeletal: Joint pain or swelling, neck pain, back pain, frequent falls

Skin: Sores, blisters, ulcers, lesions, lumps, hair and nail changes, itching

Neurological: Numbness, tingling, burning, seizure disorder, headache, dizziness, fainting, focal weakness, Tremor, poor balance, speech problems, confusion

Psychiatric: Depression, anxiety, memory loss, suicidal ideation

Endocrine: Heat or cold intolerance, excessive thirst, change in appetite

Hematologic: Abnormal bleeding
VII  EFFECTS OF PAIN ON ACTIVITIES

PLEASE CIRCLE THE ITEMS WHICH YOUR PAIN INTERFERES WITH:

<table>
<thead>
<tr>
<th>APPETITE</th>
<th>SOCIAL ACTIVITIES</th>
<th>HOUSEWORK</th>
<th>SEXUAL ACTIVITIES</th>
<th>SLEEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOBBIES</td>
<td>FRIENDSHIPS</td>
<td>MARRIAGE</td>
<td>HOUSEWORK</td>
<td>FAMILY</td>
</tr>
</tbody>
</table>

OTHER, EXPLAIN: _____________________________________________________________________________________________________________________________________________________________

WHAT IS THE MOST IMPORTANT ACTIVITY YOUR PAIN INTERFERES WITH? ________________________
____________________________________________________________________________________

HOW WOULD YOU DESCRIBE YOUR DAILY ACTIVITY? (PLEASE CIRCLE)

BED REST MODERATELY ACTIVE SEDENTARY VERY ACTIVE

IS YOUR FAMILY SUPPORTIVE OF YOUR PAIN PROBLEM? YES _____ NO _____

ABILITY QUESTIONNAIRE

When you have pain you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself TODAY. When you read a sentence that describes you today, put a mark next to it. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only mark the sentence if you are sure that it describes you today.

1. ______ I stay at home most of the time because of my pain.
2. ______ I change position frequently to try to get my back comfortable.
3. ______ I walk more slowly than usual because of my pain.
4. ______ Because of my pain, I am not doing any of the jobs that I usually do around the house.
5. ______ Because of my pain, I use a handrail to get upstairs.
6. ______ Because of my pain, I lie down to rest more often.
7. ______ Because of my pain, I have to hold on to something to get out of an easy chair.
8. ______ Because of my pain, I try to get other people to do things for me.
9. ______ I get dressed more slowly than usual because of my pain.
10.______ I only get up for short periods of time because of my pain.
11.______ Because of my pain, I try not to bend or kneel down.
12.______ I find it difficult to turn over in bed because of my pain.
13.______ I am in pain almost all of the time.
14.______ I find it difficult to get out of a chair because of my pain.
15.______ My appetite is not very good because of my pain.
16.______ I have trouble putting on my socks (or stockings) because of my pain.
17.______ I only walk for short distances because of my pain
18.______ I sleep less well because of my pain.
19.______ Because of my pain, I get dressed with help from someone else.
20.______ I sit down for most of the day because of my pain.
21.______ I avoid heavy jobs around the house because of my pain.
22.______ Because of my pain, I am more irritable and bad tempered with people than usual.
23.______ Because of my pain, I go upstairs more slowly than usual.
24.______ I stay in bed most of the time because of my pain.
(List in Minutes or Hours)

HOW LONG AT ONE TIME I CAN DO THESE VARIOUS ACTIVITIES WITHOUT A BREAK: AT THE JOB I WAS DOING WHEN I WAS HURT I WAS REQUIRED TO BE ABLE TO DO THESE ACTIVITIES FOR A MAXIMUM OF ? HRS PER DAY:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Minutes/Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit</td>
<td></td>
</tr>
<tr>
<td>Walk</td>
<td></td>
</tr>
<tr>
<td>Lift</td>
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<tr>
<td>Bend</td>
<td></td>
</tr>
<tr>
<td>Squat</td>
<td></td>
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<tr>
<td>Climb</td>
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<tr>
<td>Kneel</td>
<td></td>
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<tr>
<td>Twist</td>
<td></td>
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<tr>
<td>Stand</td>
<td></td>
</tr>
</tbody>
</table>

WHAT STUDIES HAVE BEEN PERFORMED?

X-RAYS               MRI’S               CT SCAN               EMG               OTHER _______________________________________

AT WHAT FACILITY WERE THESE TESTS PERFORMED? ___________________________________________________________
_______________________________________________________________________________________________________

TREATMENTS AND THERAPIES (PLEASE CHECK THOSE YOU HAVE HAD & THE RESULTS)

PHYSICAL THERAPY       HELPED       DID NOT HELP

EXERCISES/LAND    ________________________________
AQUATICS            ________________________________
TENS                  ________________________________
HEAT                  ________________________________
TRACTION             ________________________________
MASSAGE              ________________________________
CHIROPRACTIC MANIPULATION ________________________________
NERVE BLOCK INJECTION ________________________________
EPIDURAL STEROID INJECTION ________________________________
TRIGGER POINT INJECTION ________________________________
BRACES               ________________________________
CERVICAL COLLAR    ________________________________
CERVICAL PILLOW     ________________________________
OTHER                ________________________________
SINCE YOUR PAIN BEGAN, CHECK AND NAME THE FOLLOWING PROFESSIONALS YOU HAVE CONSULTED FOR TREATMENT AND PAIN RELIEF:

<table>
<thead>
<tr>
<th>SPECIALIST</th>
<th>NAME</th>
<th>DATE</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIROPRACTOR</td>
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<tr>
<td>DENTIST</td>
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<td></td>
<td></td>
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<tr>
<td>EAR, NOSE, THROAT</td>
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<tr>
<td>NEUROLOGIST</td>
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<tr>
<td>NEUROSURGEON</td>
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<tr>
<td>ONCOLOGIST</td>
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<tr>
<td>ORTHOPEDIST</td>
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<tr>
<td>PSYCHIATRIST</td>
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<tr>
<td>PSYCHOLOGIST</td>
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<td>ONCOLOGIST</td>
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<tr>
<td>RHEUMATOLOGIST</td>
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<td>SURGEON</td>
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<tr>
<td>OTHER</td>
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</table>

THANK YOU FOR FILLING OUT THIS PAIN QUESTIONNAIRE.

PLEASE HAND THE FORM TO A STAFF MEMBER WHEN ENTERING THE OFFICE, OR YOU CAN RETURN IT TO THE OFFICE PRIOR TO YOUR FIRST APPOINTMENT.

WE LOOK FORWARD TO MEETING YOU AT YOUR FIRST APPOINTMENT

DR. JOSEPH M. THOMAS, DR. JUNG-WOO MA AND STAFF