Tri-State Pain Institute
ADVANCED TREATMENT. PROVEN RELIEF.

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PLEASE TRY TO ANSWER ALL QUESTIONS ON THESE SHEETS.

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: _____

_____

_____

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 _____ WEIGHT _____

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:

APPETITE SOCIAL ACTIVITIES HOUSEWORK SEXUAL ACTIVITIES SLEEP
HOBBIES FRIENDSHIPS MARRIAGE HOUSEWORK FAMILY
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:

Sit	_____ Minutes/Hours
Walk	_____ Minutes/Hours
Lift _____#	_____ Minutes/Hours
Bend	_____ Minutes/Hours
Squat	_____ Minutes/Hours
Climb	_____ Minutes/Hours
Kneel	_____ Minutes/Hours
Twist	_____ Minutes/Hours
Stand	_____ Minutes/Hours

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:

Sit	_____ Minutes/Hours
Walk	_____ Minutes/Hours
Lift _____#	_____ Minutes/Hours
Bend	_____ Minutes/Hours
Squat	_____ Minutes/Hours
Climb	_____ Minutes/Hours
Kneel	_____ Minutes/Hours
Twist	_____ Minutes/Hours
Stand	_____ Minutes/Hours

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:

SPECIALIST	NAME	DATE	TREATMENT
CHIROPRACTOR			
DENTIST			
EAR,NOSE,THROAT			
NEUROLOGIST			
NEUROSURGEON			
ONCOLOGIST			
ORTHOPEDIST			
PSYCHIATRIST			
PSYCHOLOGIST			
ONCOLOGIST			
RHEUMATOLOGIST			
SURGEON			
OTHER			

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