Pain Questionnaire (1)

Patient Name (Print): _____ DOB: _____ Date of Evaluation: _____

PAIN DESCRIPTION

CC: What is your chief complaint today (area of the body)? _____

1. Please list the painful areas (most painful to least painful): _____
2. Onset: Approximately when did the pain start? _____
3. How did the pain start (ex: injury, accident, no apparent reason) and what worsens your pain (ex: sitting, walking)?

   _____
4. Is your pain (check one): ❑ Continuous/Constant ❑ Intermittent
   If Intermittent, what time or day is your pain at its worse? ❑ AM ❑ Noon ❑ PM ❑ Night
5. Please check all of the descriptions that fit your current pain:

❑ Sharp	❑ Aching	❑ Pins/Needles	❑ Shooting
❑ Heavy	❑ Numbness	❑ Throbbing	❑ Tender
❑ Tingling	❑ Cramping	❑ Splitting	❑ Weakness
❑ Stabbing	❑ Tiring	❑ Pulling	❑ Gnawing
❑ Sickening	❑ Hot/Burning	❑ Cutting	❑ Other: _____

6. Does your pain travel or radiate to any other part of your body? ❑ No ❑ Yes, where: _____
7. Do you have any accidental bowel movements or urination due to pain, spine injury or surgery? ❑ No ❑ Yes
8. What makes your pain BETTER: _____
9. What makes your pain WORSE: _____
10. On a scale from **0** to **10** with "0" representing no pain and "10" representing the most severe pain imaginable (ex: child birth, broken bones) which number would best describe your pain? Please write a number for each.
    a. Pain Score for **TODAY**: _____
    b. Pain Score **DAILY AVERAGE**: _____
    c. Pain Score WITH **MEDICATION** (if taking any): _____
11. Have you tried any of the following for your current pain and what relief did it give you?

❑ Chiropractic Therapy	❑ Great Relief	❑ Short-Term Relief	❑ No Relief
❑ Massage Therapy	❑ Great Relief	❑ Short-Term Relief	❑ No Relief
❑ Physical Therapy	❑ Great Relief	❑ Short-Term Relief	❑ No Relief
❑ NSAIDS (Advil, Aleve)	❑ Great Relief	❑ Short-Term Relief	❑ No Relief
❑ Rest	❑ Great Relief	❑ Short-Term Relief	❑ No Relief

GENERAL MEDICAL HISTORY

12. Have you had any imaging in the past 24 months (if yes please bring the report)? ❑ MRI ❑ X-Ray ❑ CT ❑ None
13. Have you had any surgeries in the past? ❑ No ❑ Yes, what type? _____
14. Have you seen any other specialist for your chronic pain? ❑ No ❑ Yes, who? _____
15. List all medications you are currently taking and how much (please include dosage strength): _____

    _____
16. List all medications you have tried that are helpful: _____
17. List all medications you have tried that were NOT helpful: _____

List all the medications that you are allergic to and what kind of reaction(s) you have had:

Name of Medication	Affected Area: Skin, Stomach, Anaphylactic	Type of Reaction: Rash, itch, Nausea, etc.	Severity: Mild, Moderate, Severe

18. **Please check all of the medical conditions you are currently being treated for:**

❑ Angina (Heart Attack)	❑ Emphysema	❑ Irregular Heart Beat	❑ Peptic Ulcer Disease
❑ Anxiety Disorder	❑ Fibromyalgia	❑ Irritable Bowel Syndrome	❑ Reflux Disorder
❑ Asthma	❑ Gastritis	❑ Kidney Failure	❑ Rheumatoid Arthritis
❑ Bi-Polar Disorder	❑ Heart Failure	❑ Migraine Headaches	❑ Seizure
❑ Cancer	❑ Hepatitis A, B, or C	❑ Mitral Valve Prolapse	❑ Stress Incontinence
❑ Cirrhosis	❑ HIV Infection	❑ Osteoarthritis	❑ Stroke
❑ COPD	❑ Hypertension	❑ Pancreatitis	❑ Tension Headache
❑ Depression	❑ Hyperthyroidism	❑ Panic Disorder	❑ Tuberculosis
❑ Diabetes Type I or II	❑ Hypothyroidism	❑ Paralysis	❑ Other: _____

PSYCHOSOCIAL HISTORY

1. Do you smoke? ❑ No ❑ Yes, _____ packs per day for _____ years.
2. Do you consume alcoholic beverages? ❑ No ❑ Yes, how much? _____ **drinks** ❑ Daily ❑ Weekly ❑ Monthly
3. Do you have a history of illicit drug use? ❑ No ❑ Yes (please check which drugs you currently use/used in the past.)

   ❑ Amphetamine ❑ Cocaine ❑ Ecstasy (MDMA) ❑ Heroin ❑ LSD (Acid) ❑ Marijuana
   ❑ Methamphetamine ❑ OxyContin ❑ Oxycodone ❑ Other: _____
4. Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Divorced ❑ Separated ❑ Widowed
5. Do you have Children? ❑ No ❑ Yes, how many? _____
6. Highest Level of Education: _____ Are You Employed? ❑ No ❑ Yes
7. Are you on disability? ❑ No ❑ Yes, how long? _____ ❑ Weeks ❑ Months ❑ Years Cause: _____
8. Do you have an attorney ❑ No ❑ Yes, what reason? _____
9. Do you have a history of childhood sexual, physical or mental trauma? ❑ No ❑ Yes, what kind? _____
10. Do you have a family history of addiction? ❑ No ❑ Yes, whom and what kind? _____

REVIEW OF SYMPTOMS

Please check all symptoms you are CURRENTLY experiencing:

Constitutional:	❑ Chills	❑ Difficulty Sleeping	❑ Fever	❑ Unexplained Weigh Change
Cardiovascular:	❑ Chest Pain	❑ Edema	❑ Fainting Spells	❑ Palpitations ❑ Poor Circulation
Endocrine:	❑ Excessive Sweating	❑ Excessive Thirst	❑ Low Sex Drive	
Gastrointestinal:	❑ Abdominal Pain	❑ Black Tar in Stool	❑ Constipation	❑ Diarrhea
Genitourinary:	❑ Bladder Incontinence	❑ Blood in Urine	❑ Frequent Urination	❑ Painful Urination
Gynecological:	❑ Endometriosis	❑ Irregular Menstruation	❑ Pelvic Pain	❑ Vaginal Discharge
Hematologic/Lymphatic:	❑ Easy Bruising	❑ Excessive Bleeding	❑ Swollen Lymph Nodes	
Musculoskeletal:	❑ Joint Pain	❑ Joint Weakness	❑ Muscle Spasms	
Neurological:	❑ Headaches	❑ Loss of Balance	❑ Loss of Consciousness	
	❑ Memory Loss	❑ Numbness/Tingling	❑ Seizures	
Psychiatric:	❑ Depressed Mood	❑ Feeling Anxious	❑ Insomnia	❑ Panic Disorder
Respiratory:	❑ Coughing	❑ Shortness of Breath	❑ Wheezing	
Skin:	❑ Itching	❑ Rashes		

Please list any other symptoms that are not listed above: _____

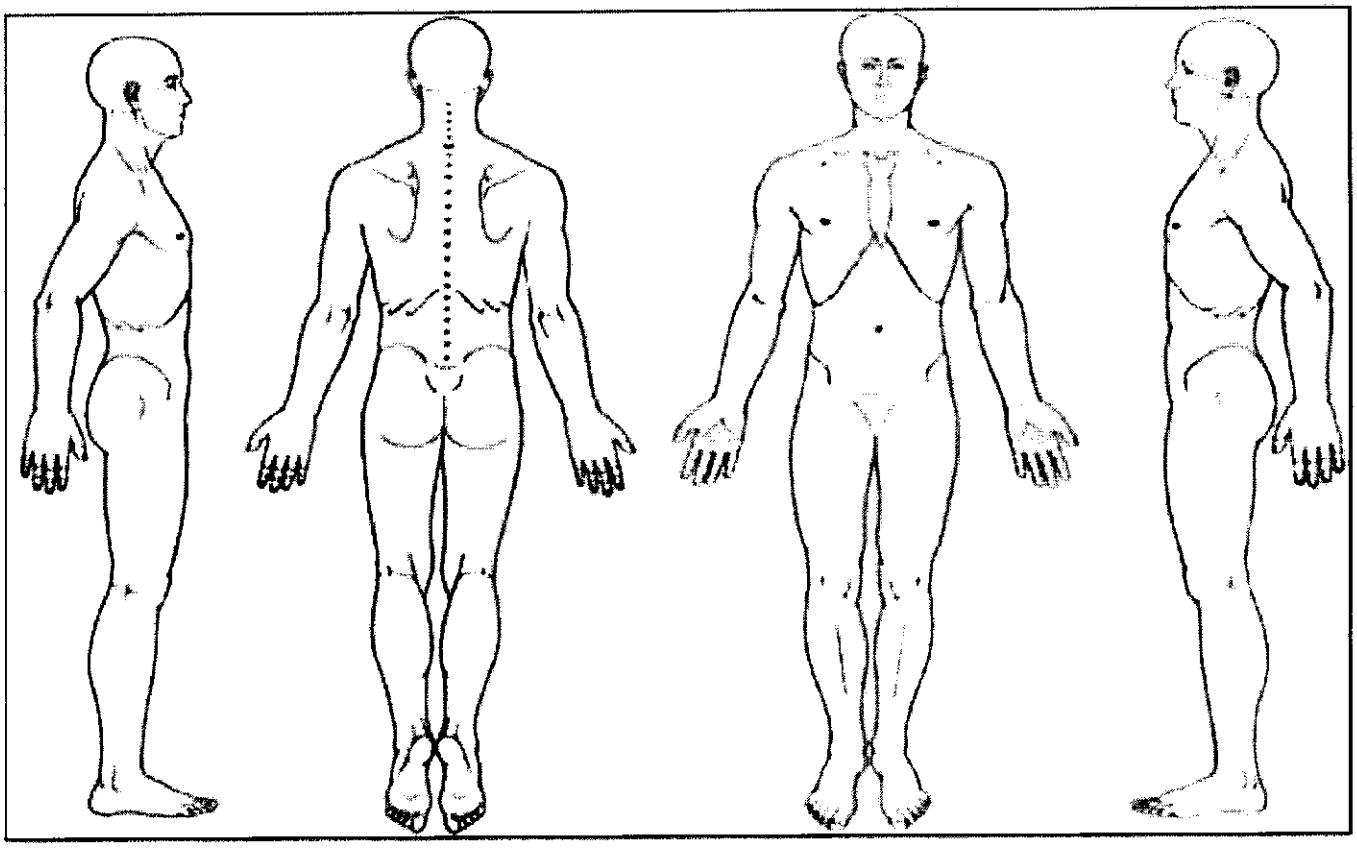
Patient Name (Print): _____ DOB: _____ **Pain Questionnaire (3)**

Please mark the location and the sensation of pain you are experiencing using the diagram and the symbols below:

A = Aching **B = Burning** **C = Cramping (Muscle)**

H = Heavy Preassure **N = Numbness** **P = Pins & Needles**

O = Other, please describe: _____



SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Patient Name: _____ DOB: _____

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

PainEDU.org

Patient Name: _____ DOB: _____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

PainEDU