

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?

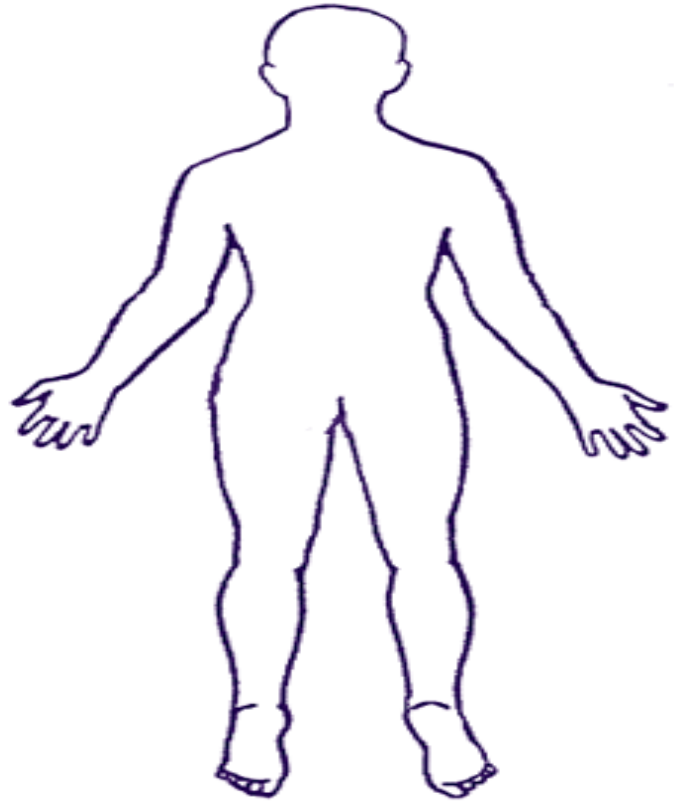
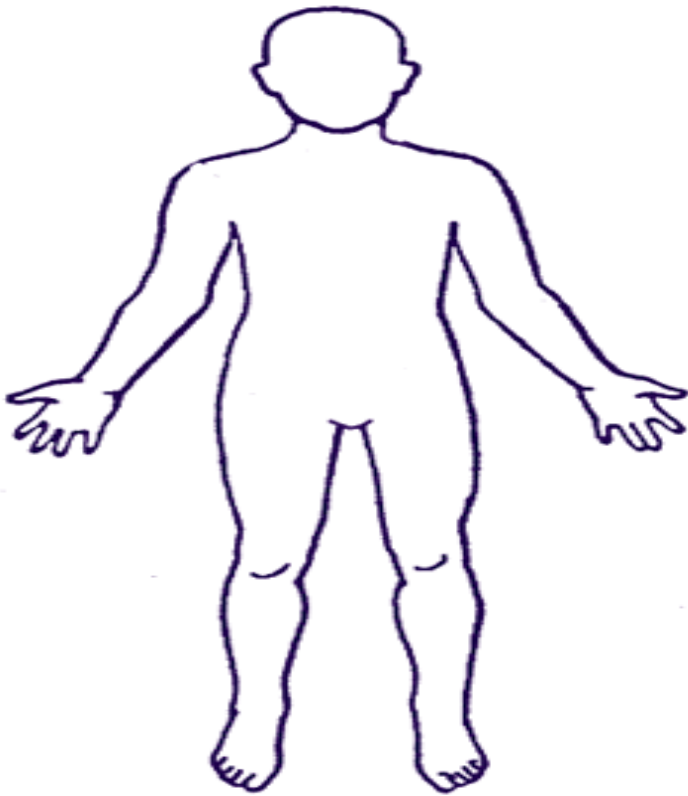
Please list 3 goals you would like to achieve as a result of medical treatment.

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:

<u>Medication</u>	<u>Discontinued Reason</u>		<u>Discontinued Reason</u>
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	_____
Avinza	_____	MSIR	_____
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 there 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
