

FROM PAIN TO WELLNESS
PAIN QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Today's Date _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ - _____ Birth Date: ____/____/____ Age: _____
month day year

Work Phone: (_____) _____ - _____ Place of Birth: _____

Person to contact in case of emergency: _____ Phone: _____

Primary Medical Insurance Carrier: _____

Secondary Medical Insurance Carrier: _____

Referring Physician (if you had): Name: _____ Phone _____

Primary Care Physician (must have): Name: _____ Phone _____

Name and phone number of any other physicians you are currently seeing: _____

Occupation: _____ Social Security Number: _____

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A) Expectations:

What are your expectations for this evaluation? _____

B) Pain History: Please rank current problem.

1. What is your chief pain problem? _____

2. When did the pain first begin (Date): _____

3. Under what circumstances?

- Accident at work, At work, but not an accident, Accident at home, Auto accident, Following surgery, Following an illness, Pain just began, Other reason: _____

4. Where is your main pain?

- Headaches, Head, Neck - not radiating down arms, Neck - radiating down arms (Left or Right or Both), Shoulders (Left or Right or Both), Arms (Left or Right or Both), Hands (Left or Right or Both), Chest, Upper Back, Ribs (Left or Right or Both), Abdomen, Pelvis, Lower Back- not radiating down legs, Lower Back - radiating down legs (Left or Right or Both), Buttocks/Thighs (Left or Right or Both), Legs (Left or Right or Both), Feet (Left or Right or Both), Whole Body, Pain in Joints Only, Other (Describe) _____

5. On a scale of 0 to 10, where 0 is no pain, 5 is moderate pain and 10 is the worst pain you ever had in your entire life, your average pain throughout the day is _____ and ranges from (the least) _____ to (the most) _____.

6. How often do you have pain? Constantly (80-100% of the time), Nearly constantly (50-80% of the time), Intermittently (25-50% of the time), Occasionally (less than 25% of the time)

7. In general, when is your pain the worst? Morning, Afternoon, Evening, No typical pattern

8. Please check what makes your pain feel worse:

- Walking, Lifting, Bending, Lying, Weather/temperature changes, Standing, Sitting, Rest, Exercise, Touch, Heat, Cold, other: _____

9. Please check what makes your pain feel better:

- Walking, Lifting, Bending, Lying, Weather/temperature changes, Standing, Sitting, Rest, Exercise, Touch, Heat, Cold, other: _____

10. Please describe your pain, check 3 that apply the most:

- Tingling, Throbbing, Sharp/Stabbing, Shooting, Numbness, Burning, Aching, Pulling, Dull, Pressure-like, Vice-like, Pins & Needles, Electric shock-like, Other: _____

11. Indicate if the pain is associated with any of the following:

- Weakness (Where?), Numbness (Where?), Constipation, Diarrhea, Bladder accidents, Bladder retention, Sexual Dysfunction, Blackout/Falls, Psychological, Other _____

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Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Back pain	Moderate	Aleve	A little
a.			
b.			
c.			
d.			
e.			
f.			
g.			

C) Treatments: What treatments have you previously had for this pain and were these treatments helpful?

Date(s)	Treatment and How Many Times	Helpful	Not Helpful
	Surgery(s)		
	Muscle/Nerve Block(s)		
	TENS/MENS or another Electrical treatment		
	Physical Therapy		
	Occupational Therapy		
	Professional Psychological or Psychiatric Support		
	Meditation/Prayer		
	Other:		

D) Social History:

1. Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

3. Do you have any pets or farm animals? Yes ___ No ___
 If yes, where do they live? 1. ___ indoors 2. ___ outdoors 3. ___ both indoors and outdoors

4. Have you lived or traveled outside of the United States? Yes ___ No ___
 If so, when and where? _____

5. Have you or your family recently experienced any major life changes? Yes ___ No ___
 If yes, please comment: _____

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6. Have you experienced any major losses in life? Yes____ No____
 If so, please comment: _____

7. How important is religion (or spirituality) for you and your family’s life?
 a. _____ not at all important
 b. _____ somewhat important
 c. _____ extremely important

8. How much time have you lost from work or school in the past year?
 a. _____ 0-2 days
 b. _____ 3 –14 days
 c. _____ > 15 days

9. Current jobs/roles:

 Last worked: _____

10. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?
 Yes No
- b. Have you been involved in abusive relationships in your life?
 Yes No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
 Yes No
- d. Do you currently feel safe in your home?
 Yes No
- e. Do you feel safe, respected and valued in your current relationship?
 Yes No
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
 Yes No
- g. Would you feel safer discussing any of these issues privately?
 Yes No

11. How well have things been going for you? (List continues on next page).

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					

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f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					
	Never	Seldom	Sometimes	Frequently	Always
During the past month have you been tense or anxious?					
During the past month have you been depressed or discouraged?					
During the past month have you been irritable and upset?					
When you are in pain how often is your husband/wife/other family member supportive and encouraging?					
When you are in pain how often does your husband/wife/other family member ignore you or become angry?					

12. Have you ever had psychotherapy or counseling? Yes ___ No ___
 Currently? ___ Previously? ___ If previously, from ___ to _____.
 What kind? _____
 Comments: _____

13. Are you currently, or have you ever been, married? Yes ___ No ___
 If so, when were you married? _____ Spouse's occupation _____
 When were you separated? _____ Never ___
 When were you divorced? _____ Never ___
 When were you remarried? _____ Never ___ Spouse's occupation _____
 Comments: _____

14. Hobbies and leisure activities: _____

E) Past Medical and Surgical History:

1.

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		

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ILLNESSES	WHEN	COMMENTS
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		
q. High blood pressure (hypertension)		
r. Irritable bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Psychological (Depression, Bipolar illness, Schizophrenia, etc)		
w. Rheumatic fever		
x. Sinusitis		
y. Sleep apnea		
z. Stroke		
aa. Thyroid disease		
ab. Other (describe)		
INJURIES	WHEN	COMMENTS
ac. Back injury		
ad. Broken (describe)		
ae. Head injury		
af. Neck injury		
ag. Other (describe)		
DIAGNOSTIC STUDIES	WHEN	COMMENTS
ah. Barium Enema		
ai. Bone Scan		
aj. CAT Scan of Abdomen		
ak. CAT scan of Brain		
al. CAT Scan of Spine		
am. Chest X-ray		
an. Colonoscopy		
ao. EKG		
ap. Liver scan		
aq. Neck X-ray		
ar. NMR/MRI		
as. Sigmoidoscopy		
at. Upper GI Series		
au. Other (describe)		

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OPERATIONS	WHEN	COMMENTS
av. Appendectomy		
aw. Dental Surgery		
ax. Gall Bladder		
ay. Hernia		
az. Hysterectomy		
ba. Tonsillectomy		
bb. Other (describe)		
bc. Other (describe)		
bd. Other (describe)		

2. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

3. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

F) Medication/Supplement History

1. How often have you have taken antibiotics?

< 5 times > 5 times

Infancy/ Childhood		
Teen		
Adulthood		

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2. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?
< 5 times > 5 times

Infancy/ Childhood		
Teen		
Adulthood		

3. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

4. Are you allergic to any medications? Yes ___ No ___
 If yes, please list: _____

5. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

G) Diet and Elimination History:

1. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes ___ No ___

If yes, please: name the food and symptom (Example: milk – gas and diarrhea) _____

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2. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page).

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

3. How much of the following do you consume each week? (List continues on next page)

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

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12. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes ___ No ___
 If yes, which one(s)? ___ lead ___ cadmium
 ___ arsenic ___ mercury
 ___ aluminum

13. Do odors affect you? Yes ___ No ___

J) Functional History

1. Do you exercise regularly? Yes ___ No ___
 If so, how many times a week? When you exercise, how long is each session?
 1. ___ 1x 1. ___ ≤15 min
 2. ___ 2x 2. ___ 16-30 min
 3. ___ 3x 3. ___ 31-45 min
 4. ___ 4x or more 4. ___ > 45 min

What type of exercise is it?
 ___ jogging/walking ___ tennis
 ___ basketball ___ water sports
 ___ home aerobics ___ other _____

2. Please indicate accurately what things you are definitely unable to do because of pain.

Activity	Able to do	Difficult but can do	Cannot do
Bathing Self			
Dressing Self			
Toileting self			
Getting out of bed			
Walking			
Performing household chores			
Shopping or doing yard work			
Driving			
Working			
Doing recreational activities or hobbies			
Having sexual relations			
Physical exercise			
Socializing with friends and/or family			

How often during the day are you inactive because of pain? Constantly (80-100% of the time) Most of the time (50-80% of the time) Significantly (30-50% of the time) Occasionally (less than 30% of the time)

What is your present maximum sitting/standing time and walking distance?

Sitting time: No sitting problem Mild problem (Have to get up after 2 hours or more) Moderate (Have to get up after about an hour) Moderately severe (Have to get up after about 1/2- 3/4 hour) Severe (Have to get up after 10-15 minutes or less)

Standing time: No standing problem Mild problem (Have to stop standing after 2 hours or more) Moderate (Have to stop standing after about an hour) Moderately severe (Have to stop standing after about 1/2- 3/4 hour) Severe (Have to stop standing after 10-15 minutes or less)

Walking distance: No walking problem Mild problem (Have to stop after 1 mile or more) Moderate (Have to stop after 1/2- 3/4 mile) Moderately severe (Have to stop after a few blocks) Severe (Have to after 1 block or less)

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Communication:

Do you have difficulty with: Understanding? Yes No Speaking? Yes No Vision? Yes No
Hearing? Yes No Please describe:

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____