SPINE PAIN DIAGNOSTICS ASSOCIATES

K. Liao

Pain Questionnaire

Date: _____

Name: _____ DOB: _____ Age: _____

Who referred you to this practice? _____

Who is your primary care physician? _____

MAIN reason for this visit: _____

_____

_____

_____

WHEN AND HOW did the pain start? _____

_____

_____

_____

_____

For Nurse use only: Vital Signs

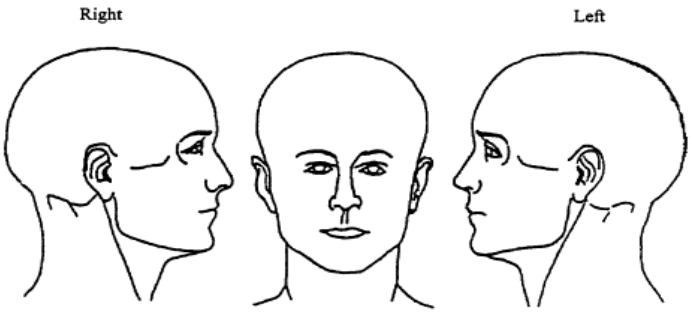
B/P: _____ HR: _____ RR: _____ T: _____ SpO2: _____

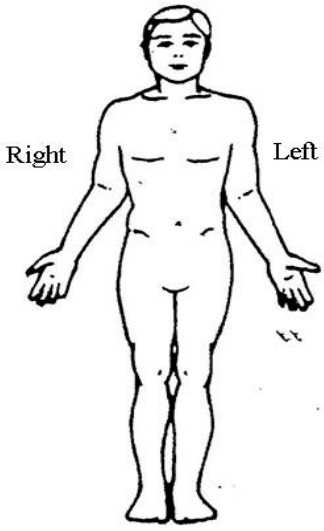
Height: _____ Weight: _____ BMI: _____

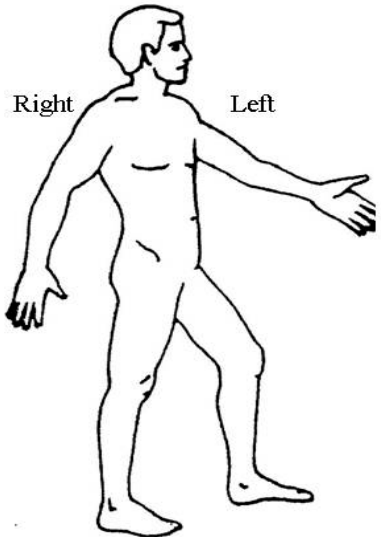
Nurse comments:

Nurse/Admitter Signature: _____ Date: _____

Please shade in your painful areas on the diagrams.

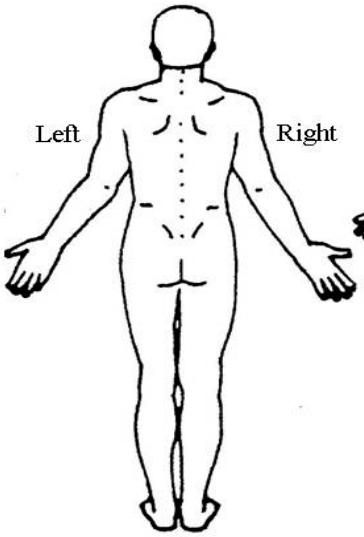


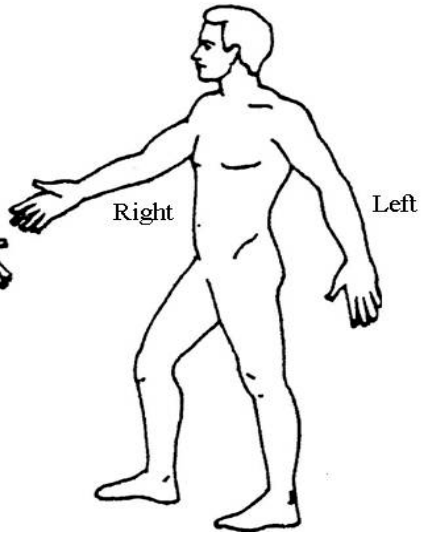




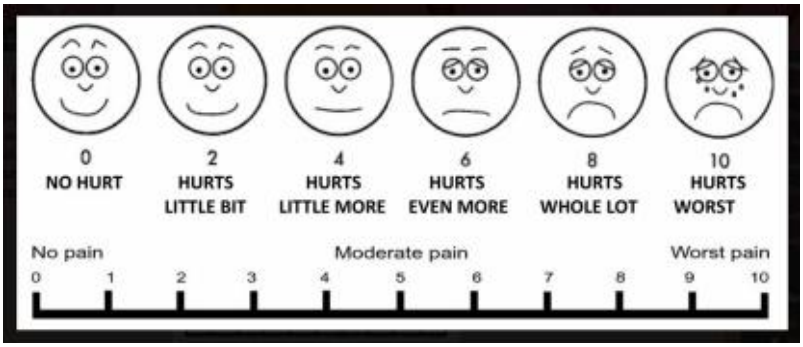
FOR NURSE USE ONLY:
PAIN DISTRIBUTION

REFERRED OR RADIATION





PAIN SCALE VAS:



Using the pain scale above (0 – 10), please give a number to the pain you experience doing the following things:

Resting pain level (sitting, lying down): _____

Daily activity pain level (while walking, standing, dressing, etc.): _____

Strenuous activity pain level: _____ What activities? _____

Pain level with medication? _____

Average /Typical pain level: _____

Acceptable pain level? _____

	Yes	No
Does your pain interrupt your sleep?		
Is your pain worse at night compared to daytime?		
Does your pain affect your daily activities?		

Is your pain: ☐ Constant ☐ Off & On ☐ Occasional ☐ With activity ☐ At rest

Briefly describe your pain:

	Yes	No
Burning Pain		
Gnawing Pain – Continuous with constant intensity worsen with movement		
Muscle Pain		
Pressing Pain		
Referred Pain – Pain sensation felt in a site other than that is actually occurring		
Stabbing Pain		
Throbbing Pain		
Other		

Aggravating or Relieving Factors
Please check which of the following activities change the nature of your pain.

	Increases Pain	No change	Decreases Pain
When you first get out of bed			
Getting up			
Sitting			
Standing			
Leaning forward			
Walking			
Climbing stairs			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Stooping			
Lifting			
Bending backwards			
Turning			
Other			
Other			

☐ Pain occurs at rest or with activity (pain is not relieved by anything).

Do you experience any of the following symptoms?

	Yes	No				
Unexplained weight loss / gain						
Current infection/get infection easily						
Fracture or suspected fracture						
Numbness in genitalia/anal region						
Loss of bladder control/unable to hold			Old symptom?	How long?	New symptom?	How long?
Loss of bowel control/unable to hold			Old symptom?	How long?	New symptom?	How long?
Weakness			Where?			
Numbness			Where?			
Tingling			Where?			

Please indicate which of the following have been used to treat your *present condition*, and if it was helpful or not. Please also indicate where and when you had the treatment.

	Yes	No	Helpful	Not Helpful	Made Worse	Where/When/How Long
Surgeries (please list in spaces below):						
Medications (please list in spaces below):						
Physical Therapy						
Chiropractic						
Injection Therapy						
Other (massage, acupuncture, TENs unit, comprehensive pain management, etc.)						

Have you had recent medical or surgical opinion? Yes _____ No_____
When? _____ Where? _____
Physician Name: _____

Please list your prescription medications. Please include all medications, such as for pain, blood pressure, diabetes, eye/ear drops, inhaled medications, etc. **By giving us this information, you give permission for us to check with your pharmacy if there are questions about your current medications.**

Medication	Dose	How often/when do you take it?	Prescribing Doctor	Pharmacy

Please list non-prescription medications (Tylenol, Advil, Prilosec, Vitamins, Supplements, etc.):

Medication	Dose	Times/Day

Do you have allergies to any of the following?

Medications (please list below):	Yes	No	Symptoms
Cortisone/Steroids			
Local anesthetics (Novacaine, etc.)			
Iodine			
Latex			
Tape			
Contrast Dye			

Medical History: Please check all current or past medical conditions

Cancer:

Type:

Date of diagnosis:

Type of treatment:

Length of treatment:

Oncologist:

Clearance:

Remission: Y N Cured: Y N

Head and Face:

- ☐ Cluster headache
- ☐ Migraine headahe
- ☐ Tension or stress headache

Eyes:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration

Ears:

- ☐ Chronic or frequent ear infection
- ☐ Hearing loss

Mouth and Throat:

- ☐ Sleep Apnea

Cardiovascular:

- ☐ Aneurysm
- ☐ Atrial fibrillation
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Deep vein thrombosis (blood clots in deep veins)
- ☐ Elevated blood cholesterol
- ☐ Heart valve defect
- ☐ Hypertension
- ☐ Peripheral vascular disease
- ☐ Raynaud's disease

Respiratory:

- ☐ Asthma
- ☐ Chronic obstructive pulmonary disease/Emphysema
- ☐ Pneumonia

Gastrointestinal:

- ☐ Chronic constipation
- ☐ Cirrhosis
- ☐ Gastroesophageal reflux (GERD)
- ☐ Hepatitis
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Stomach ulcer

Kidney/Urinary:

- ☐ Stress incontinence
- ☐ Kidney disease
- ☐ Renal failure

Musculoskeletal:

- ☐ Ankylosing spondylitis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Chronic fatigue syndrome
- ☐ Disk disorder in back
- ☐ Disk disorder in neck
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Scoliosis

Neurologic:

- ☐ Dementia
- ☐ Neuralgia
- ☐ Paralysis
- ☐ Progressive neurologic disorder
- ☐ Restless leg syndrome
- ☐ Stroke (CVA)

Mental Health:

- ☐ Alcohol or Drug treatment
- ☐ Alcoholism
- ☐ Chronic anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Drug dependency
- ☐ IV drug abuse
- ☐ Post-traumatic stress disorder
- ☐ Sexually abused

Endocrine

- ☐ Type I diabetes
- ☐ Type II diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Hematologic and Lymphatic:

- ☐ Anemia
- ☐ Clotting disorder
- ☐ Idiopathic thrombocytopenic purpura

Immunologic:

- ☐ Autoimmune Disorders
- ☐ HIV Positive
- ☐ MRSA

Others:

Please list any other surgeries you had, including where and when you had them.

Surgery	Where	When

Have you had any of the following?

Indicate region of the body	Yes	No	Where	When
MRI				
CT scan				
Myelogram				
X-ray				
EMG				
Bone scan				
Bone Density				

Immunization

Influenza Vaccination ☐ Yes ☐ No When_____

Diagnostic and Screening Test

Stomach and Digestive System: Colonoscopy ☐ Yes ☐ No When_____

Fecal Occult Blood Testing ☐ Yes ☐ No When_____

Reproductive System (Female only) : PAP Smear ☐ Yes ☐ No When_____

Mammography ☐ Yes ☐ No When_____

Family History of Illnesses & Diseases

	Living	Deceased	Age	Back Problems	Osteoporosis	Arthritis	Diabetes	Other: Cancer, Heart Disease, Blood clots
Mother								
Father								
Children								
Siblings								

Employment

Are you currently working? ☐ Yes (☐ Part-time ☐ Full-time) ☐ No ☐ Retired

If yes, please describe occupation, including job tasks:

_____

Has pain forced you to stop working or limited your capacity at work? ☐ Yes ☐ No

Are you under any work restrictions (please list below)? ☐ Yes ☐ No

_____

How long have you been off work, or restricted at work, due to pain? _____

Is this a Workman's Comp case? ☐ Yes ☐ No

Is there litigation involved? ☐ Yes ☐ No

Personal History

What is the highest level of education you have completed? _____

Current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner

Do you currently smoke or use tobacco? ☐ Yes ☐ No (How much? _____ For how long? _____)

Have you ever smoked/used tobacco? ☐ Yes ☐ No (How much? _____ For how long? _____)

Do you currently smoke/use marijuana? ☐ Yes ☐ No (How much? _____ For how long?_____)

Do you drink alcohol? ☐ Yes ☐ No (How much? _____ ☐ daily ☐ weekly ☐ rarely)

Are you using illegal drugs? ☐ Yes ☐ No (which drugs: _____)

Consequences of alcohol or drug use? ☐ DUI ☐ Job loss ☐ Illness ☐ Injury ☐ Incarceration

History of prescription drug abuse? ☐ Yes ☐ No (which drugs: _____)

Do you have a living will? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

Do you exercise? ☐ Regularly ☐ Occasionally ☐ Never (why? _____)

I hereby confirm that all of the above information is true to the best of my knowledge. I give consent to history taking and physical examination by Spine Pain Diagnostics Associates physicians and their designees.

_____

Signature of patient or legal representative

Person assisting with filling out this questionnaire: _____

REVIEW OF SYSTEMS

Have you experienced any of the following?

Yes

CONSTITUTIONAL:

- ☐ Change in appetite
- ☐ Increased dizziness
- ☐ Excessive daytime sleepiness
- ☐ Fatigue
- ☐ Fever and chills
- ☐ General aching
- ☐ Sleeping problems
- ☐ Unintentional weight gain
- ☐ Unintentional weight loss

EYES:

- ☐ Loss of vision
- ☐ Pain in one or both eyes

EARS, NOSE, MOUTH AND THROAT:

- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Hoarseness or other voice changes
- ☐ Snoring
- ☐ Sore throat

CARDIOVASCULAR:

- ☐ Blacking out/fainting
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Leg cramps or leg pain with short distance walking
- ☐ Shortness of breath only when lying down
- ☐ Shortness of breath while sitting or standing
- Swelling including ankles or legs

☐ **RESPIRATORY:**

- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Snoring
- Wheezing

☐ **GASTROINTESTINAL:**

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal pain
- ☐ Painful swallowing
- Vomiting

☐ **PSYCHOLOGICAL:**

- ☐ Arrested for driving while intoxicated
- ☐ Difficulty maintaining long-term relationships
- ☐ Easily upset or irritated
- ☐ Feels nervous
- ☐ Feels sad more than usual
- ☐ Suicidal attempts or gestures in the past
- ☐ Suicidal thoughts
- Trouble sleeping

Yes

ENDOCRINE:

- ☐ Increased appetite
- ☐ Decreased interest in sex
- ☐ Increased thirst
- ☐ Urinating more than usual

GENITOURINARY:

- ☐ Pain during sex
- ☐ Blood in urine
- ☐ Difficulty starting or stopping urination
- ☐ Difficulty holding urine
- ☐ Dripping after urination
- ☐ Hesitancy when urinating
- ☐ Incontinence with coughing, sneezing, laughing or straining
- ☐ Pain or burning with urination

MUSCULOSKELETAL (BONES, JOINTS AND MUSCLES):

- ☐ Bone deformities
- ☐ Decreased in sizes of muscles
- ☐ Loss of muscle strength
- ☐ Muscle pain
- ☐ Painful joints
- ☐ Stiffness in joints
- ☐ Stiffness in neck
- ☐ Swelling of joints
- ☐ Weakness

INTEGUMENTARY (SKIN):

- ☐ Poor wound healing
- ☐ Skin itching
- ☐ Skin rashes
- ☐ Ulcers

NEUROLOGICAL:

- ☐ Difficulty remembering
- ☐ Difficulty in thinking
- ☐ Difficulty walking
- ☐ Difficulty with balance
- ☐ Difficulty with coordination
- ☐ Headache
- ☐ Loss of bladder control
- ☐ Loss of bowel control
- ☐ Seizures
- ☐ Tremors
- ☐ Paralysis

HEMATOLOGICAL/ LYMPHATIC:

- ☐ Bleeds excessively after injury or minor surgery
- ☐ Bruises easily
- ☐ Bone pain
- ☐ Uses blood thinners

ALLERGIC, INFECTIOUS AND IMMUNOLOGIC:

- ☐ Food intolerance
- ☐ Infections recurring
- ☐ Multiple aching joints with fever
- ☐ Rash after contact with specific substance
- ☐ History of MRSA infection

For Motor Vehicle or Work Injuries

Motor Vehicle accident? ☐ Yes ☐ No Any previous accidents? ☐ Yes ☐ No

Work related? ☐ Yes ☐ No Any previous injuries? ☐ Yes ☐ No

Date of injury: _____

Are you in litigation? ☐ Yes ☐ No

Describe in detail how your injury occurred:

_____

_____

_____

_____

_____

_____

Did you have immediate pain? ☐ Yes ☐ No

Did you seek treatment immediately? ☐ Yes ☐ No Where? _____

What kind of treatment? _____

If you were involved in a motor vehicle accident, please answer the following:

Driver? ☐ Yes ☐ No Head on? ☐ Yes ☐ No Tail spin? ☐ Yes ☐ No

Passenger? ☐ Yes ☐ No Broadside? ☐ Yes ☐ No Rollover? ☐ Yes ☐ No

Seatbelt? ☐ Yes ☐ No Rear end? ☐ Yes ☐ No

If a police report was filed, please attach a copy, along with any other records or documentation pertinent to this case.

Patient Signature: _____ Date:_____