V. Singh, MD

Date:_____________

PAIN QUESTIONNAIRE

Name:____ **Date of birth:**__________________ **Age:**__________

Who referred you to this practice? (newspaper, TV, doctor, friend etc..)________________________________

Who is your primary care physician:____

Where is your MAIN pain located? ____

____

____

When did the pain start? ____

____

How did the pain start? ____

____

____

Was your pain due to an accident or major trauma (car accident, fall, job related injury, etc.)?
If so please explain on next page.

FOR NURSE USE ONLY: VITAL SIGNS

B/P: __________________ **HR:** __________________ **RR:** __________________ **T:** _________________

HEIGHT:__________________ **WEIGHT:** _____________________

Nurse Comments: ____

____

____

____

Nurse Signature: ____ **Date:** __________________________

Name: ___________________________________ Date of Birth: ____________________________

If your pain is **a result of a WORK RELATED injury or MVA WITH OPEN CLAIM** please explain what happened:

____
____
____
____
____

Date of injury:__________________

Are you in litigation? ☐Yes ☐No

Mechanism of injury (What happened: If car accident, how fast, where were you sitting [driver, back passenger, etc.], were you wearing a seatbelt, was there damage to the car, were you transported to the hospital, etc…)

____
____
____
____
____
____

Did you have pain immediately? ☐Yes ☐No

Did you seek treatment immediately? ☐Yes ☐No Where/What?________________________________

What type of treatments have you had for this pain?___________________________Where?___________

What?____

If a police report was filed please attach copy and any other records pertinent to this case

Signature____

History of sequence of events:

Please list (by date) who you have seen for ***this*** problem, list any tests (MRI, CT scan, etc) and treatments (surgeries, medications, physical therapies, chiropractic manipulations, acupuncture, braces, injections, pain programs) you have had related to your pain.

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Name: ___________________________________ Date of Birth: ____________________________

Please check "Yes" to those that apply to your pain description.
Please be sure to include the location of the type of pain.

Burning?	☐Yes	☐ No	Location:_______________________
Stabbing?	☐Yes	☐No	Location:_______________________
Electric shocks?	☐Yes	☐No	Location:_______________________
Spasm?	☐Yes	☐No	Location:_______________________
Sharp?	☐Yes	☐No	Location:_______________________
Aching?	☐Yes	☐No	Location: _______________________
Throbbing?	☐Yes	☐No	Location: _______________________
Dull?	☐Yes	☐No	Location:_______________________
Radiating?	☐Yes	☐No	Location:_______________________
Vice like?	☐Yes	☐No	Location:_______________________

Other (please describe): ____

What time of day do you experience the most pain? ___________________________

How often? ☐ Occasional/episodic ☐ Constant ☐ Only at night

Do you experience any of these symptoms?

Weakness?	☐Yes	☐No	Location:______________________
Numbness?	☐Yes	☐No	Location:______________________
Tingling (pins & needles)?	☐Yes	☐No	Location:______________________
Changes in skin color?	☐Yes	☐No	Location:______________________
Cold skin?	☐Yes	☐No	Location:______________________
Loss of bowel control?	☐Yes	☐No	Explain: ______________________
Loss of bladder control?	☐Yes	☐No	Explain: ______________________
Male impotence?	☐Yes	☐No	
Dropping things?	☐Yes	☐No	
Fever?	☐Yes	☐No	
Recent or unexplained weight loss?	☐Yes	☐No	

Name: ______________________________ Date of Birth: ________________________

Activities that Increase / Decrease 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			
Alcohol			
Other: please specify			

Do you take medications to decrease your pain? ☐Yes ☐No
Please list?____

Name: ___________________________________ Date of Birth: ____________________________

Please SHADE IN the area of Pain your being seen for today

Right

Left

Right

Left

Right

Left

Left

Right

Right

Left

PAIN SCALE VAS: 0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Possible Pain

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 activity? ___________________________

Average pain level: __________ Worst pain level: __________ With medication: __________

Using the same pain scale (0-10) what do you feel is an acceptable pain level for you? ________

Name: ___________________________ Date of Birth: _____________________

Please describe treatments you have tried for your specific pain problem in the past and what effects they have had on your pain:

	When	Where	Improvement	Worsened	No Change
Surgery					
Medications					
Physical therapy					
Chiropractic					
Brace					
Acupuncture					
Injections					
Pain Program					
Other					

Please check the tests you have had for this problem and indicate when and date they were done and of what part of your body:

Test	What Area of Body	Date	Where
☐X-RAY			
☐MRI			
☐CAT SCAN			
☐MYELOGRAM			
☐EMG			
☐BONE SCAN			
☐DISCOGRAM			

Other____

Name: ______________________________ Date of Birth: ________________________

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___________

Allergies (Please list allergens and describe what happened.)

Allergen	***Reaction***

Have you ever had an allergic reaction to:

Contrast Dye? ☐Yes ☐No
Describe Reaction: ____

Cortisone/Steroids? ☐Yes ☐No
Describe Reaction: ____

Local anesthetics (Novacaine, Xylocaine) ☐Yes ☐No
Describe Reaction: ____

Please list your **Prescription** medications, including **Pain** medicine and any **other** (high blood pressure medication, diabetes medications, eye or ear drops, inhalers, etc.)

Birth control method (female): ____

MEDICATION	DOSE	TIMES DAILY	PRESCRIBING DOCTOR

Name: ___________________________________ Date of Birth: ____________________________

MEDICATION	DOSE	TIMES DAILY	PRESCRIBING DOCTOR

Please list any **other medications** you are taking & how often: (Including ASPIRIN, Anti-inflammatory medications such as Advil, Aleve, Tylenol & Vitamins, etc…)

____

____

____

Are you taking **blood thinners**? ☐Yes ☐No (ex: Aspirin, Plavix, Xarelto, Coumadin, Eliquis)

If so, why? ____

What doctor has you on the blood thinner? ______________________________________

Please list any medications that you felt **helped** your pain:______________________________

____

Please list any medications tried that **were not helpful**:_________________________________

____

Name: ______________________________ Date of Birth: ________________________

Please list any surgeries you have had, including when and where:

Surgery type	Date	Where

Family History / Illness / Diseases:

	Back Problems	Diabetes	Osteoporosis	Arthritis	Other (Cancer, Blood circulation Problems, i.e. blood clots)
Mother ⇧⇩					
Father ⇧⇩					
Children					
Siblings					
Other					

Name: ________________________________ Date of Birth: __________________________

Medical History: Please check all current or past medical conditions:

Cancer:

Type: ____________________________

Date of diagnosis:__________________

Type of treatment:

Length of treatment:

Oncologist:

Remission: Y N

Cured: Y N

Head / Face / Throat:

☐ Cluster headache
☐ Migraine headache
☐ Tension or stress headache
☐ Cataracts
☐ Glaucoma
☐ Macular Degeneration
☐ Chronic or frequent ear infection
☐ Hearing loss
☐ Sleep apnea

Endocrine:

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

Cardiovascular:

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

Respiratory:

☐ Asthma
☐ COPD / Emphysema

_☐ Pneumonia

Kidney/Urinary:

☐ Stress Incontinence
☐ Kidney disease ☐ Renal failure

Gastrointestinal:

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

Musculoskeletal:

☐ Ankylosing spondylitis
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Chronic fatigue syndrome
☐ Disc disorder in neck
☐ Disc disorder in back
☐ 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 ☐ Drug dependency
☐ Chronic anxiety ☐ Depression
☐ Bipolar disorder
☐ Post-traumatic stress disorder (PTSD)
☐ Sexually abused

Immunologic:

☐ Autoimmune disorder ☐ MRSA ☐ HIV

Hematologic and Lymphatic:

☐ Anemia ☐ Clotting disorder
☐ Idiopathic thrombocytopenic purpura

Name: ________________________________ Date of Birth: _________________________

Personal History:

What is your current marital status? ☐Single ☐Living with Partner ☐Married ☐Divorced ☐Widowed

What is the highest level of education you've completed?___________________________________

Do you smoke or use tobacco? ☐Yes ☐No *(How much)* _____________ *(How long)* ______________

Have you ever smoked / used tobacco? ☐Yes ☐No *(How much & for how long)*_________________

Have you ever smoked / used marijuana? ☐Yes ☐No *(How much & for how long)*_________________

Do you drink alcohol? ☐Yes ☐No *If Yes, how much? Daily* _____ *Weekly* _____

Do you use illegal drugs? ☐Yes ☐No *Have you in the past (explain)*______________________

Do you have a history of prescription drug ***abuse?***____

Have you had problems with alcohol or drug use? (DUI/loss of job /illness /injury/incarceration)
____

Do you have a **living will**? ☐Yes ☐No

Do you have a durable power of attorney for **healthcare**? ☐Yes ☐No **Is it activated**? ☐Yes ☐No

Are you pregnant or planning to become pregnant? ☐Yes ☐No N/A

Do you exercise? ☐Regularly ☐Occasionally ☐Never Why?: _________________

How do you sleep? ☐Enough ☐Not enough ☐Interrupted by pain

EMPLOYMENT STATUS:

Are you currently working? ☐Yes (☐ full time ☐ part time) ☐No ☐Retired

If yes, please describe your occupation including job tasks:
____

Has pain forced you to stop working or limited your capacity at work?_______________________

Work restrictions:____

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

Is this a Worker's Compensation case? ☐ Yes ☐ No

Is there litigation involved? ☐ Yes ☐ No

Name: ________________________________ Date of Birth: _________________________

Currently do you have any of the following conditions:

Skin:
- ☐ None
- ☐ Lumps ________________________
- ☐ Dry skin
- ☐ Changes in appearance of texture
- ☐ Changes in color
- ☐ Rashes_________________________
- ☐ Sweaty skin
- ☐ Changes to hair or nails

Respiratory System:
- ☐ None
- ☐ Shortness of breath
- ☐ Heavy cough
- ☐ Coughing up blood
- ☐ Emphysema/Bronchitis
- ☐ Asthma
- ☐ T.B. (Tuberculosis)
- ☐ Other_______________________

Nose/Mouth/Throat:
- ☐ None
- ☐ Sores/ulcers
- ☐ Sinus problems
- ☐ Neck pain/stiffness/swelling
- ☐ Voice changes
- ☐ Difficulty or pain swallowing
- ☐ Other__________________________

Vision/Hearing:
- ☐ None
- ☐ Decreased vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Decreased hearing
- ☐ Ringing in the ears
- ☐ Other_______________________

Nervous System:
- ☐ None
- ☐ Headache
- ☐ Depression
- ☐ Nervousness
- ☐ Panic attacks
- ☐ Psychiatric disorder___________________
- ☐ Head trauma
- ☐ Seizures/epilepsy
- ☐ Dizziness/lightheadedness
- ☐ Tremors/shaking
- ☐ Fainting spells
- ☐ Stroke/mini-stroke
- ☐ Insomnia
- ☐ Memory loss
- ☐ Other______________________________

Cardiovascular System:
- ☐ None
- ☐ Previous heart attack
- ☐ Chest pain
- ☐ Irregular heart beats/palpitations
- ☐ Congestive heart failure
- ☐ Heart valve problems
- ☐ Swelling/edema_______________
- ☐ High blood pressure
- ☐ Bleeding/bruising
- ☐ Blood clots___________________
- ☐ Pacemaker
- ☐ Anemia
- ☐ Poor circulation
- ☐ Rheumatic fever
- ☐ Other________________________

Digestive System:
- ☐ None
- ☐ Change in bowel habits
- ☐ Heartburn/ulcers
- ☐ Blood in stool
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Other______________________________

Reproductive System:
- ☐ None
- ☐ Pregnant/trying to become pregnant
- ☐ Female organ problems
- ☐ Sexually transmitted diseases
- ☐ Unusual penis or vaginal discharge
- ☐ Impotence/loss of libido
- ☐ Other________________________

Name: _____________________________ Date of Birth: _______________________

Liver/Pancreas/Thyroid/Glands:
- ☐ None
- ☐ Yellow eyes
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Swollen glands
- ☐ Hepatitis/liver disorder
- ☐ Excessive thirst or hunger
- ☐ Excessive sweating
- ☐ Other____________________________

Urinary System:
- ☐ None
- ☐ Frequent urination
- ☐ Difficulty starting urination
- ☐ Painful urination
- ☐ Urinary retention
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ **Women**: Urinary stress incontinence
- ☐ **Men**: Abnormal prostate condition
- ☐ Other____________________________

General:
- ☐ None
- ☐ **Tumor/Cancer**_________________________
- ☐ Chills
- ☐ Night sweats
- ☐ Severe fatigue
- ☐ Generalized weakness
- ☐ Loss of Appetite
- ☐ Undesired weight loss
- ☐ Fever
- ☐ HIV/AIDS
- ☐ Tick bite reaction
- ☐ Recent cold or other illness
- ☐ Increased appetite
- ☐ Undesired weight gain
- ☐ Other_______________________________

Joints:
- ☐ None
- ☐ Arthritis (where)______________________
- ☐ Stiffness (where)______________________
- ☐ Swelling (where)______________________
- ☐ Other________________________________

I hereby confirm that all 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 filing out this questionnaire________________________________

Comments:____

Name: ______________________________ Date of Birth: ________________________

Name: ______________________________ Date of Birth: ________________________