SJ Pain Physician
Patient Questionnaire

NAME: ________________________
Last, First, Middle Initial

Current Marital Status:
( ) Married ( ) Divorced
( ) Single ( ) Widowed

PAIN HISTORY

1. When did your present episode of pain begin? _____Year _____Month _____Day
2. Describe the pain in your own words.______________________________________

____

3. What makes it worse ? ____
4. What makes it better? ____

PAIN DESCRIPTION

5. Check to describe the pattern of your pain.

( ) Continuous
( ) Steady
( ) Constant
( ) Rhythmic
( ) Periodic

( ) Intermittent
( ) Brief
( ) Momentary
( ) Transient

6. Check which best describes the type of pain.

( ) Burning
( ) Shooting
( ) Cramping
( ) Aching
( ) Crushing
( ) Pulling

( ) Gnawing
( ) Throbbing
( ) Pounding
( ) Sharp
( ) Stabbing
( ) Tender

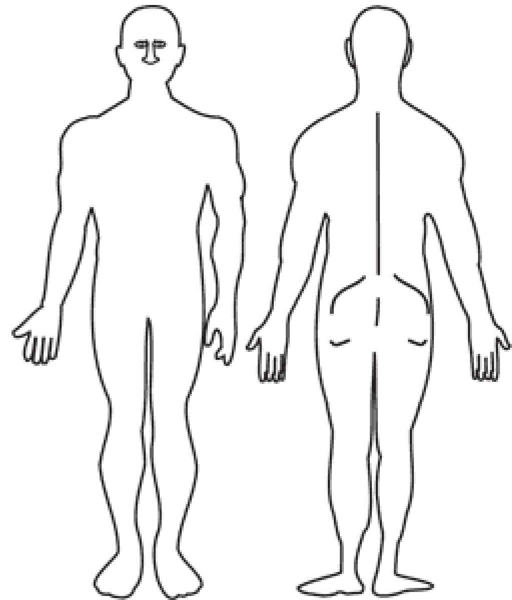
7. On a scale of 0-10, 0 represents no pain and 10 the very worst……

How would you score your pain today? ______ (1-10)
What is your daily average pain? ______(1-10)
How would you score your worst pain from this injury? _______(1-10)

8. Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness ---- Pins & Needles oooo

Burning xxxx Stabbing ////



Front Back

9. Are you allergic to any medications? ( ) Yes ( ) No
   If so, list: ____
   ____

11. Do you smoke? ( ) Yes ( ) No
    If yes, number of packs per day: ____
    How long have you smoked? ____

12. Do you drink alcoholic beverages? ( ) Yes ( ) No
    How may drinks per day ________________ or per week ______________________?

MEDICAL HISTORY

Height: __________ Weight: __________

13. Have you ever had any of the following?

( ) Rheumatic Fever
( ) Scarlet Fever
( ) Diabetes
( ) Epilepsy, Seizures
( ) Hemophilia
( ) Bleeding Tendencies
( ) Blood Disease
( ) Anemia
( ) Asthma
( ) Tuberculosis
( ) High Blood Pressure
( ) Lung Disease
( ) Heart Disease
( ) Liver Disease
( ) Hepatitis
( ) Gallbladder Disease
( ) Kidney Disease
( ) Thyroid Disease
( ) Colon Problems
( ) Stomach Problems
( ) Emotional Problems
( ) Joint Disease/Arthritis
( ) Measles
( ) Mumps
( ) Chicken Pox
( ) Ulcers
( ) Stroke
( ) Cancer

14. Have you had any surgeries? ( ) Yes ( ) No
Please list operations and approximate dates:

______________________________ ____________________________________

______________________________ ____________________________________

WORK HISTORY

15. What is your occupation? ____
16. Are you working now? ____
17. If not currently working, how long have you been off work? ________________
18. Are you currently receiving Workers' Compensation (disability income)?
( ) Yes ( ) No
19. Are you currently in the process of trying to obtain compensation (disability benefits)? ( ) Yes ( ) No
20. Are you involved in any litigation (are you suing anyone) related to your pain?
( ) Yes ( ) No

21. Have you had to be off work for pain problems in the past?
( ) Yes ( ) No For how long? __________________________________