Kernan Orthopaedics and Rehabilitation

PAIN MANAGEMENT CENTER

PATIENT QUESTIONNAIRE

We are interested in understanding more about your pain. Please help us by filling out this questionnaire.

Date:________________________________

Name:________________________________ Date of Birth:______________

Primary Care Physician: **Referring Physician (if different):**

Name:________________________________ Name:_____________________

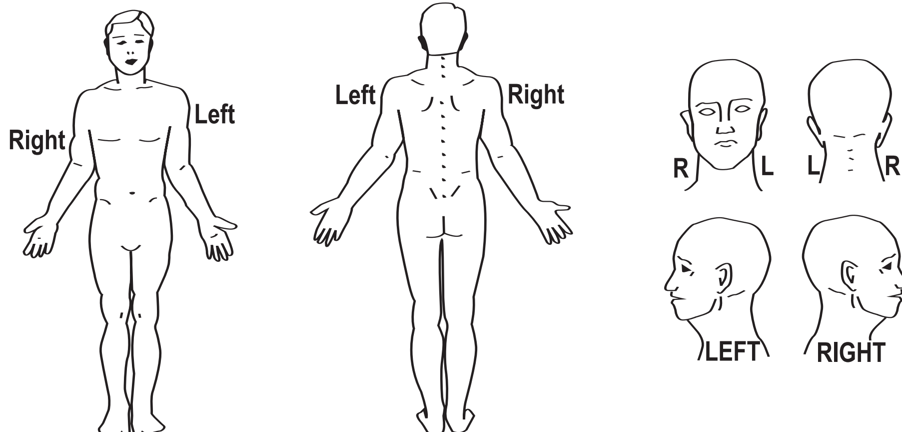
Address:______________________________ Address:___________________

______________________________________ ___________________________

______________________________________ ___________________________

Phone:________________________________ Phone:_____________________

1. Where is the location of you pain?____
   Please use the diagram below to indicate where your most painful areas are located. Shade in these areas darkly and shade in your less painful areas lightly.



2. When did your pain problem begin, or if your pain is related to a specific injury, what date did the injury occur? Month:__________ Day:__________ Year:__________

3. How did your pain first start? (Car accident? Fall? Job related injury? Etc.)

____

____

4. Please circle the level of your pain for the following:

AVERAGE daily level of pain:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst pain imaginable)

Using the same scale, what level of pain is ACCEPTABLE for you?

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst pain imaginable)

5. How often do you have pain? Please circle one. **Constant** **Intermittent (Occasionally)**

6. Circle the words below which best describe your pain and related symptoms:

Dull Sharp Shooting Stabbing Burning Electric Aching

Numbness Tingling Weakness Coldness Spasms or Tightness

7. Are there things that influence your pain? Please check all that apply.

TREATMENT	WORSENS	RELIEVES	NO DIFFERENCE	COMMENTS
Exercise				
Walking				
Massage				
Sitting				
Standing				
Temperature (hot)				
Temperature (cold)				
Weather				
Emotional Stress				
Sexual Activity				
Medicines				
Stairs				
Other:				

KERNAN ORTHOPAEDICS AND REHABILITATION

PAIN MANAGEMENT CENTER

PATIENT QUESTIONNAIRE

8. What medications for pain have you tried in the past?

____
____
____
____

9. What treatments have you had in the past for your pain? Please check all athat apply.

TREATMENT	HELPFUL	NOT HELPFUL	COMMENTS
Surgery			
Nerve blocks			
Steroid injection			
Acupuncture			
Trigger point injection			
TENS unit			
Heat/ice treatment			
Biofeedback			
Hypnosis			
Relaxation training			
Counseling			
Physical therapy			
Other:			

10. Please circle any of the following medical conditions you now have or have had in the past:

Diabetes **Arthritis** **Cancer** **Ulcer** **Heart Problems** **Bleeding Problems**

Kidney Problems **Respiratory Problems (COPD/Asthma)** **Seizures**

Infectious Disease **Neurogenic Disease** **High Blood Pressure**

Other:____

11. Have you ever been seen by another pain specialist? **Yes** **No**

If so, what is the name of the doctor or practice? ________________________________

12. Are you currently working? **Yes** **No** **Retired**

Describe your current or past occupation: ________________________________

13. Are you being treated under Worker's Compensation? **Yes** **No**

14. Are you currently receiving or applying for disability benefits? **Yes** **No**

KERNAN ORTHOPAEDICS AND REHABILITATION

PAIN MANAGEMENT CENTER

PATIENT QUESTIONNAIRE

15. Are you involved in any legal action related to your pain problem or considering it in the future? Please circle: **Yes** **No**

16. Circle any of the following tests you have had in the past 24 months:

    X-ray **CT Scan** **MRI** **EMG**

17. Please list all past surgeries/hospitalizations:

DATE	SURGERY OR REASON FOR HOSPITALIZATION

18. Please list all your **current** medications, including "over the counter medications" below: If more room is needed, use the back side of this paper.

MEDICATION	STRENGTH (how many milligrams?	TOTAL DAILY DOSE	IS IT EFFECTIVE? (yes, no, or somewhat)	ORDERING PHYSICIAN

KERNAN ORTHOPAEDICS AND REHABILITATION

PAIN MANAGEMENT CENTER

PATIENT QUESTIONNAIRE

19. Please list all of your **ALLERGIES:** ____________________

____

35. Do you have a history of or experience any of the following symptoms or problems?
Please circle **Yes** or **No** for each problem.

Yes	**No**	Blurry vision
Yes	**No**	Glaucoma
Yes	**No**	Ringing in your ears
Yes	**No**	Clenching your teeth
Yes	**No**	Tightness in your chest or chest pain
Yes	**No**	Heart disease or irregular heart beats
Yes	**No**	Need to sleep sitting up in order to get your breath
Yes	**No**	Difficulty breathing
Yes	**No**	Emphysema or asthma
Yes	**No**	Abdominal pain
Yes	**No**	Stomach ulcers or gastritis
Yes	**No**	Irregular bowels
Yes	**No**	Irritable bowel disease
Yes	**No**	Blood in your stools
Yes	**No**	Pelvic pain
Yes	**No**	Frequent urination
Yes	**No**	Inability to urinate
Yes	**No**	Seizures
Yes	**No**	Frequent headaches
Yes	**No**	Episodes of blacking out or passing out
Yes	**No**	Unexplained fevers
Yes	**No**	Excessive fatigue
Yes	**No**	Difficulty falling or staying asleep
Yes	**No**	Rashes
Yes	**No**	Rheumatoid arthritis, lupus, sarcoid or scleroderma
Yes	**No**	Diabetes
Yes	**No**	Thyroid problems
Yes	**No**	Depression
Yes	**No**	Anxiety

I have reviewed this list with the patient____________________

(For physician use only) Physician Signature/Date and Time