

ADVANCED PAIN MEDICINE PATIENT QUESTIONNAIRE

Patient Name: _____ **Referring Physician:** _____

Age: _____ **Date of Birth:** _____ **Family Doctor:** _____

Greatest Area of Pain _____

Other Areas of Pain _____
When did it start _____
(mo/yr)? _____

Was this due to an injury? Yes / No
Please describe:

Please shade in your areas of pain on the picture below:

Rate your pain on a scale of 1 (best) to 10 (worst) at its most **SEVERE:**

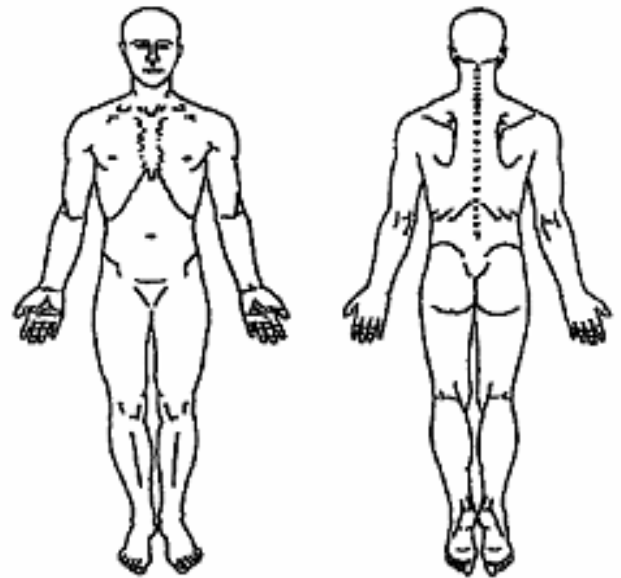
best **0 1 2 3 4 5 6 7 8 9 10** worst

Rate your pain on a scale of 0 (best) to 10 (worst) **TODAY:**

best **0 1 2 3 4 5 6 7 8 9 10** worst

Rate your pain on a scale of 0 (best) to 10 (worst) at its **BEST:**

best **0 1 2 3 4 5 6 7 8 9 10** worst



Are there any legal actions related to your pain? Yes No

√ **How do you describe your pain?**

<input type="checkbox"/>	aching
<input type="checkbox"/>	burning
<input type="checkbox"/>	dull
<input type="checkbox"/>	electrical
<input type="checkbox"/>	knifelike
<input type="checkbox"/>	sharp
<input type="checkbox"/>	shooting
<input type="checkbox"/>	stabbing
<input type="checkbox"/>	stinging
<input type="checkbox"/>	throbbing
<input type="checkbox"/>	tingling
<input type="checkbox"/>	toothache
<input type="checkbox"/>	OTHER:
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

√ **What makes your pain worse?**

<input type="checkbox"/>	arching your back
<input type="checkbox"/>	bending over
<input type="checkbox"/>	bowel movements
<input type="checkbox"/>	cooking
<input type="checkbox"/>	coughing
<input type="checkbox"/>	getting out of a chair
<input type="checkbox"/>	lying down
<input type="checkbox"/>	sex
<input type="checkbox"/>	sitting
<input type="checkbox"/>	sneezing
<input type="checkbox"/>	standing
<input type="checkbox"/>	twisting
<input type="checkbox"/>	vacuuming
<input type="checkbox"/>	walking
<input type="checkbox"/>	climbing stairs
<input type="checkbox"/>	walking down a hill
<input type="checkbox"/>	

√ **What makes your pain better?**

<input type="checkbox"/>	sitting
<input type="checkbox"/>	standing
<input type="checkbox"/>	lying down
<input type="checkbox"/>	walking
<input type="checkbox"/>	stretching
<input type="checkbox"/>	hot bath or shower
<input type="checkbox"/>	application of heat
<input type="checkbox"/>	ice
<input type="checkbox"/>	relaxation
<input type="checkbox"/>	massage
<input type="checkbox"/>	TENS unit
<input type="checkbox"/>	acupuncture
<input type="checkbox"/>	chiropractors
<input type="checkbox"/>	previous injections:
<input type="checkbox"/>	Pain medications:
<input type="checkbox"/>	

