

ADVANCED PAIN MEDICINE PATIENT QUESTIONNAIRE

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

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

Greatest Area of Pain _____

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

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

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**:

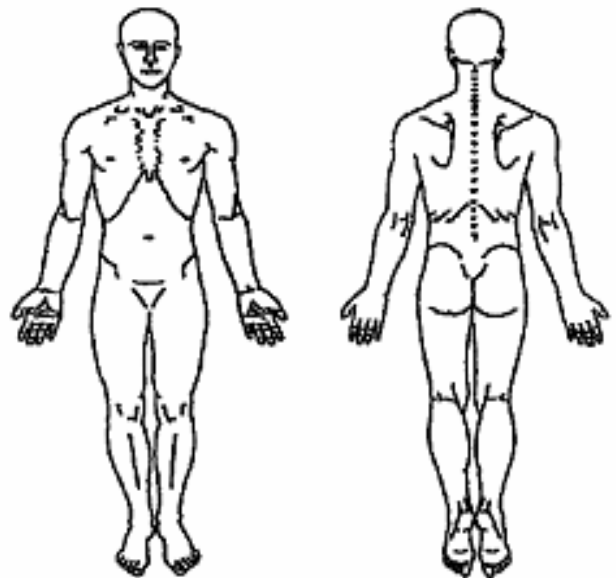
best **0 1 2 3 4 5 6 7 8 9 10** worst

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?**

aching
burning
dull
electrical
knifelike
sharp
shooting
stabbing
stinging
throbbing
tingling
toothache
OTHER:

√ **What makes your pain worse?**

arching your back
bending over
bowel movements
cooking
coughing
getting out of a chair
lying down
sex
sitting
sneezing
standing
twisting
vacuuming
walking
climbing stairs
walking down a hill

√ **What makes your pain better?**

sitting
standing
lying down
walking
stretching
hot bath or shower
application of heat
ice
relaxation
massage
TENS unit
acupuncture
chiropractors
previous injections:
Pain medications:

