Sports & Spine
Pain Management

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Initial Comprehensive Pain Questionnaire

Date of Initial Visit: ______________________

Name: ____
Last   First   Middle initial

Date of Birth: __________________________ Age: __________ Gender: __________

Best Phone Number to Reach You:___________________________ E-Mail Address: ______________________________

Emergency Contact Name: _______________________________________ Phone: ______________________________

Race: [ ] White [ ] Asian-American [ ] African-American [ ] Latino [ ] Other __________

Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Divorced [ ] Separated [ ] Widowed

Referring doctor/How did you hear about us: ____

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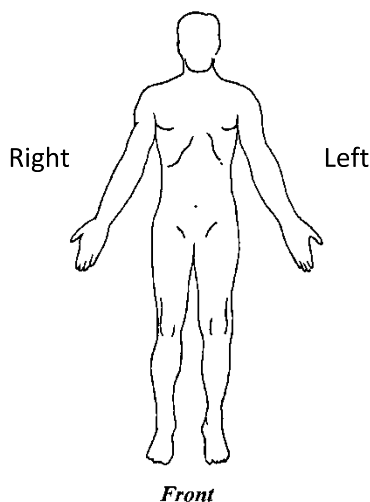
REASONS FOR VISIT:

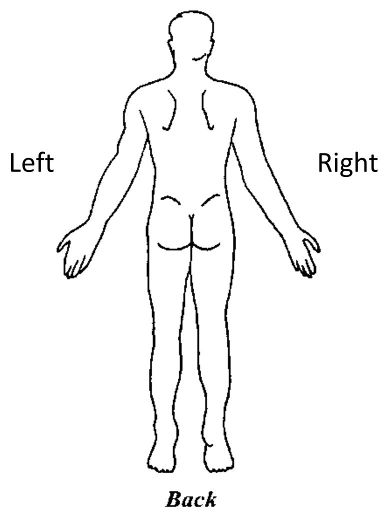
CC: Where is your Pain: ____

Name one area that hurts you the most today: ____

Pain Location: please mark the location(s) of your pain on the diagrams below with an "X". If whole areas are painful, please shade in these areas.



Front



Back

What Pharmacy do you use? (name/town etc)

1. ____
2. ____

(for example: Rite Aid, 123 Pulaski Hyw, Havre de Grace, 21078)

(For Staff Use Only)

VITALS: HT: _________ WT: _________ BP: _________ HR: ________ RR _______ Temp: ________

What level is your pain today? Pain Scale: VAS_____/10

YOUR ALLERGIES: Are you allergic to any medications? [ ] Yes [ ] No

Name of Medication:	Reaction:

Are you allergic to contrast (x-ray) dye? [ ] Yes_________________ [ ] No [ ] Don't Know

Are you allergic to latex? [ ] Yes_________________ [ ] No [ ] Don't Know

CURRENT MEDICATIONS: Please list **ALL** of your current medications, including dosage:

Medication Name	Dosage/strength (mg)	Frequency/times per day

Are you taking any **Blood thinners**? (Ex. Aspirin, Plavix, Warfain/Coumadin, Effient, Xarelto, Aggrenox, Pletal)

[ ] Yes [ ] No Names:____

FAMILY HISTORY:

Health problems in your immediate family (mother, father, sister, brother), or diseases that run in your family?

Heath Problem	Family Member

SOCIAL HISTORY:

Education: What is the highest grade or level of school you have completed/degree received?

[ ] None
[ ] Elementary school _____th grade.
[ ] High school graduate
[ ] GED or equivalent Professional/Technical training school
[ ] Some college – no diploma
[ ] Associate degree – occupational, technical, vocational
[ ] Associate degree – academic
[ ] Bachelors degree – BA, BS
[ ] Graduate degree – MA/MS
[ ] Professional school degree – MD, DO, DDS, JD, DVM
[ ] Doctoral degree - PhD

Employment: Are you currently employed?

[ ] Working Full-Time? Your occupation? ________________________________
[ ] Working Part-Time
[ ] Disabled
[ ] Retired
[ ] Student

Activities of Daily Living:

Are you blind or do you have difficulty seeing?	[ ] Yes	[ ] No
Are you deaf or do you have serious difficulty hearing?	[ ] Yes	[ ] No
Do you have difficulty concentrating, remembering, or making decisions?	[ ] Yes	[ ] No
Do you have difficulty walking or climbing stairs?	[ ] Yes	[ ] No
Do you have difficulty dressing or bathing?	[ ] Yes	[ ] No
Do you have difficulty doing errands alone?	[ ] Yes	[ ] No

Legal Issues: Please indicate any of the following claims you have filed related to your pain problem:

[ ] Worker's compensation
[ ] Motor Vehicle or Personal Injury
[ ] Social Security Disability Insurance (SSDI)
[ ] Other insurance

Diet/Exercise:

Which one best describes your current diet?

[ ] Regular [ ] Vegetarian [ ] Vegan [ ] Specific_________________
[ ] Cardiac [ ] Low Carbohydrate [ ] Gluten Free [ ] Diabetic

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? __________

SUBSTANCE ABUSE:

Smoking Hx:

Do you or have you ever been a smoker?

[ ] Yes-Currently a daily smoker [ ] Yes- Currently a non-daily smoker [ ] Yes- A former smoker [ ] No-Never smoked

How many years have you been smoking? ______years.
If you smoke, how many packs per day? ______packs per day
If you quit, how many years did you smoke for? ______years.

Do you or have you ever used any other forms of tobacco or nicotine?	[ ] Yes	No [ ]
Do you or have you ever used e-cigarettes or vape?	[ ] Yes	No [ ]
Do you or have you ever used smokeless tobacco?	[ ] Yes	No [ ]

Alcohol Hx:

What is your level of alcohol consumption? [ ] None [ ] Occasional [ ] Moderate [ ] Heavy

Do you have/ever had a history of alcoholism? [ ] Yes No [ ] [ ] This is a current problem
Have you ever been enrolled in Alcoholics Anonymous? [ ] Yes No [ ] When? __________

Public Health and Travel:

[ ] Yes No [ ] Have you been to an area known to be high risk for COVID-19?

[ ] Yes No [ ] In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill?

[ ] Yes No [ ] In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill?

Advanced Directive:

[ ] Yes No [ ] Do you have an advanced directive?

Sexual Activity:

Are you sexually active?

[ ] Yes No [ ]

Marital Status:

[ ] Single [ ] Married [ ] Divorced

[ ] Separated [ ] Widowed [ ] Domestic Partner

Lifestyle:

[ ] Yes No [ ] Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

Drug Hx:

Have you ever abused prescription pain medications?

[ ] No- never

[ ] Yes- in the past : Last use ______________

[ ] This is a current problem

Have you ever used illicit drugs? Heroin, Cocaine or intravenous drugs:

[ ] No- never

[ ] Yes- in the past : what did you use? __________ when was your last use ______________

[ ] This is a current problem

If you have a history of substance abuse, have you ever been in a detoxification, drug rehab or counseling program?

[ ] No

[ ] Yes: When? ______________________ Where ?____

Gender Identity and LGBTQ Identity:

Gender identity:

[ ] Identifies as Male [ ] Identifies as Female

[ ] Transgender Male/Female-to-Male FTM

[ ] Transgender Female/Male-to-Female MTF

[ ] Gender non-conforming

[ ] Additional __________________

[ ] Choose not to disclose

Assigned sex at birth: [ ] Female [ ] Male [ ] Unknown [ ] Choose not to disclose

Pronouns: [ ] She/Her [ ] He/Him [ ] They/Them

First Name Used:___________________________

Sexual Orientation:

[ ] Lesbian/Gay/Homosexual

[ ] Straight/Heterosexual

[ ] Don't Know

[ ] Choose not to disclose

[ ] Something else ________________________

PSYCHIATRIC HISTORY:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?
[ ] Yes [ ] No

For what diagnosis were you treated? ______________________________ Date: ______________________

Please list your current or last therapists ____

Have you ever been hospitalized for psychiatric reasons (depression, suicidal thoughts, hearing voices)? [ ] No [ ] Yes

Have you ever considered suicide? [ ] No [ ] Yes When?________________________

Have you ever planned suicide? [ ] No [ ] Yes When?________________________

Have you ever attempted suicide? [ ] No [ ] Yes When?________________________

PAST SURGICAL HISTORY:

Type of Surgery	Date

PAST MEDICAL HISTORY:

Have you had any of the following health problems (please check all that apply)?

[ ] Hypertension [ ] Coronary Artery Disease [ ] Angina or chest pain [ ] Stroke
[ ] Heart Attack [ ] Diabetes [ ] Asthma or wheezing [ ] HIV
[ ] Emphysema [ ] Kidney Disease [ ] Liver Disease [ ] Hepatitis C
[ ] COVID-19 [ ] Seizure or epilepsy [ ] Bleeding problems [ ] Thyroid disease
[ ] Depression [ ] Anxiety [ ] Sleep apnea (Use Cpap machine)
[ ] Arthritis – specify location(s): ____
[ ] Cancer- specify type/location: ____
[ ] Other problem – specify: ____

Falls:

[ ] Yes No [ ] Recent Falls? When was your last fall? ____________________

HISTORY OF PRESENT ILLNESS (HPI)

How did your pain start?

[ ] Illness
[ ] Treatment cause (i.e. surgery, radiation, etc.)
[ ] Non-work related injury
[ ] I don't know
[ ] Injury at work (date of injury __________)
[ ] Car accident (date of injury __________)
[ ] Sports injury
[ ] Other ________________________________

When did your pain begin? ________________________

Since my pain began it has: [ ] Improved [ ] Worsened [ ] Remained stable

Duration & Frequency:

How often is your pain present?
[ ] Constant [ ] Nearly constant [ ] Intermittent (on and off) [ ] Occasional (once in a while)

Severity of Pain: [ ] Mild [ ] Moderate [ ] Moderate-severe [ ] Severe

Current Pain Level (1-10): ________

Quality of Pain: How would you describe your pain?

[ ] burning [ ] sharp [ ] cutting [ ] throbbing [ ] cramping [ ] dull/aching [ ] pressure-like
[ ] shooting [ ] electrical/shock like [ ] other (describe) ________________________________

Associated Symptoms: Do you also have any of the following symptoms? (please check all appropriate):

[ ] Numbness in the [ ] Same area as your pain or [ ] Different area than your pain.
[ ] Pins and needles in the [ ] Same area as your pain or [ ] Different area than your pain.
[ ] Hair loss [ ] Skin changes / nail changes in extremities

Do you have problems with any of the following?

[ ] Weakness in ________________________________
[ ] Dropping objects [ ] Falling [ ] Tripping
[ ] Recent bowel or bladder control issues? (please describe):________________________________
[ ] Other (please describe) ________________________________

Relieving & Aggravating Factors:

What makes your pain worse or better? (please check one for each item. If an item does not apply, leave it blank).

	More Pain	No Change	Less Pain
Relaxing			
Lying Down			
Sitting			
Standing			
Getting up from a chair			
Walking			
Leaning on a shopping cart			
Walking up hill			
Walking down hill			
Coughing/Sneezing			
Bowel Movements			
Exercise			
Medication			
Physical Therapy			

Sleep Disturbance from Pain:

Do you have difficulty falling asleep? [ ] Yes [ ] No
Do you wake up middle of the night because of pain? [ ] Yes [ ] No
If you use any sleep-aids, please specify ________________________________

Previous Doctor/Clinic: Please list doctors who have treated your pain:

	Provider Name	Type of Treatments (Injections/surgery/therapy)	Dates of Treatment
Pain Management Doctor			
Orthopedic/Spine Surgeon			
Family Doctor/Primary Care			
Psychiatrist			
Neurologist			
PM&R Rehabilitation Doctor			
Physical Therapist			
Chiropractor			

Previous Tests:
Have you had an MRI, CT, X-ray, EMG, or Discogram? Please list below

Test Done	Date	Where test was done	Do you have results?

Previous Treatment & Modalities: Please check all the treatments you have tried.

TREATMENTS	No Relief	Moderate Relief	Excellent Relief
Physical or Occupational Therapy			
Chiropractic Treatments			
Psychotherapy/ Counseling			
Acupuncture			
Massage			
TENS (electrical stim)			
Heat/Ice Treatment			
Injection/Nerve Block			
Surgery			

Do you have/use a brace (check all applicable):
[ ] Back brace [ ] Knee Brace [ ] Neck Brace/collar [ ] Wrist Brace [ ] Ankle Brace [ ] Other:___________

Do you have a TENS (electric stim) device for home use? [ ] No [ ] Yes

Previous Pain Medications: Please check all you have tried and write the dose.

Opioids		Anti-inflammatory		Muscle Relaxers		Other	
	Codeine		Tylenol (acetaminophen)		Flexeril (cyclobenzaprine)		Gabapentin
	Hydrocodone (Vicodin/Lortab)		Aspirin		Amrix		Lyrica
	Tramadol (ultram/ultracet)		Ibuprofen		Soma (Carisoprodol)		Gralise
	Dilaudid (hydromorphone)		Naproxen (aleve)		Skelaxin (Metaxolone)		Amitriptyline
	Oxycodone (Percocet)		Mobic (meloxicam)		Zanaflex (Tizanidine)		
	Oxycontin		Celebrex (celecoxib)		Baclofen		
	Opana		Daypro (oxaprozin)		Parafon Forte		
	Opana ER		Indocin		Robaxin (methocarbamol)		
	Nucynta/Nucynta ER		Toradol		Lorzone		
	Morphine/MS-Contin		Relafen (nabumetone)		Valium		
	Fentanyl Patch (duragesic)		Cataflam/Arthrotec (Diclofenac)	Other:			
	Methadone		Lodine (etodolac)	Other:			

Which of these medications were helpful? ____

Side effects from medications, if any? ____

FUNCTIONAL STATUS:

Balance and Ambulation:

How far can you walk? _____________ Feet / Blocks / Miles (circle one)

Do you have problems with balance? [ ] No [ ] Yes

Do you have trouble using stairs? [ ] Going up the stairs [ ] Going down the stairs

Do you have trouble sitting? [ ] No [ ] Yes: how long can you sit? _____________

Do you use a walking device? [ ] Cane [ ] Walker [ ] Wheelchair [ ] Rollator [ ] Crutches [ ] None

Activities limited by your pain:

Are you **NOT** able to perform any of the following activities of daily living? (Check all that apply)

[ ] Going to work
[ ] Performing household chores
[ ] Doing yard work or shopping
[ ] Socializing with friends
[ ] Participating in recreational activities
[ ] Exercising
[ ] Other (specify) ____

REVIEW OF SYSTEMS: Are you ***currently*** experiencing any of the symptoms below? (Check all that apply)

Constitutional

	Fever/chills
	Night sweats
	Weight gain_____
	Weight loss _____
	Fatigue

Skin

	Jaundice
	Rash
	Skin lesions

Eyes

	Vision changed
	Blurred vision

Ears

	Hearing difficulty
	Ringing in ears
	Ear pain

Nose

	Frequent nose bleed
	Sinus problems

Mouth/throat

	Sore throat
	Bleeding gums
	Dry mouth

Cardiovascular

	Chest pain
	Palpitations
	Heart murmur

Respiratory

	Cough
	Coughing up blood
	wheezing
	Shortness of breath
	Sleep apnea

Gastrointestinal

	Decreased appetite
	Swallowing problem
	Abdominal pain
	Nausea
	Vomiting
	Vomiting blood
	Diarrhea
	Constipation
	GERD
	Black/tarry stool

Genitourinary

	Loss control of urine
	Blood in urine
	Pain with urination

Musculoskeletal

	Muscle aches
	Muscle weakness
	Joint pain
	Joint stiffness
	Joint swelling
	Decreased range of motion

Neurologic

	Loss of consciousness
	Seizures
	Dizziness
	Frequent headaches
	Memory loss
	Change in smell
	Speech problems
	Balance problems
	Walking difficulty

Sensory

	Numbness
	Burning
	Tingling
	Hypersensitivity

Endocrine

	Diabetes
	Thyroid problem
	Hair loss
	Cold intolerance

Hematologic

	Anemia
	Excessive bleeding
	Swollen glands

Psychological

	Depression
	Anxiety
	Delusions
	Hallucinations
	Suicidal ideation
	Homicidal thoughts