ASCENDANT
ORTHOPEDIC ALLIANCE
THE PAIN MANAGEMENT CENTER

PAIN QUESTIONNAIRE

Current Date __________

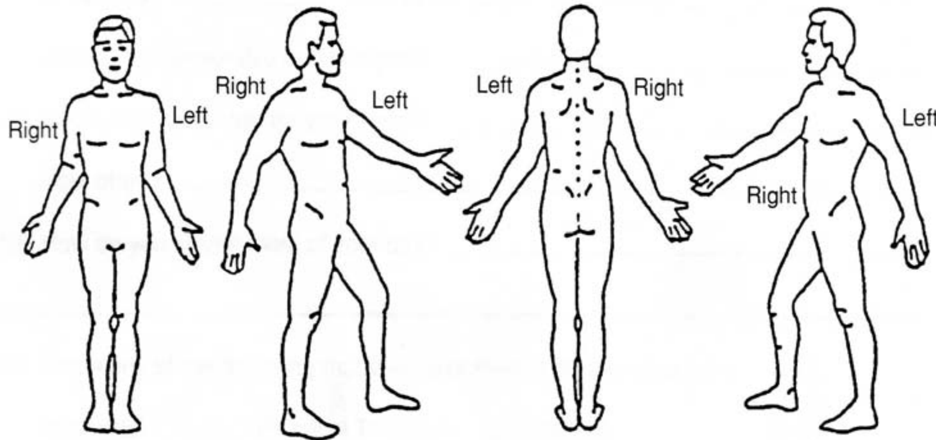
Appointment Date _________

Patient Name ____ **Date of Birth**_________________

1. **When did your pain begin?** Mo _________________ Day _______________ Yr ________________
2. **Is there a lawsuit involved as a result of a related accident or injury?** ________________________________
3. **How did your pain begin?** ____

____

4. **Please shade in the areas you are having pain:**



Pain Scale

No Pain	0
	1
Mild, annoying pain	2
	3
Nagging, uncomfortable troublesome pain	4
	5
Distressing, miserable pain	6
	7
Intense, dreadful, horrible pain	8
	9
Worst possible, unbearable, excruciating pain	10

5. **Using the Pain Scale at the right, rate your pain from 0-10:**

   At its worst ________ At its best ___________ Today ____________

6. **Circle the items that best describe your pain:**

Aching	Cold	Electric Shock	Numb	Shooting	Squeezing	Throbbing
Biting	Cramping	Hot	Persistent	Sore	Stabbing	Tight
Burning	Dull	Miserable	Sharp	Spasms	Tender	Tingling
						Unbearable

7. **How often does your pain occur? (check the ONE that is most accurate)**

   Constantly ______________ Comes during the day ______________ Starts in the morning _____________

   Intermittently occurs during the day ________________ Evening/bedtime ________________

8. **Circle the items that increase your pain:**

Arching Back	Driving	Ice	Physical Therapy	Sitting	Stepping Down	Twisting
Bending	Getting Up	Lifting	Reaching	Sneezing	Stepping Up	Walking
Coughing	Heat	Lying Down	Sex	Standing	Stress	Weather

Patient Name ____ **Date of Birth**_______________

9. Circle the items that decrease your pain:

Heat	Massage	Pressure	Standing	Other: ______________________________
Ice	Medicine	Relaxation	Walking	
Lying Down	Physical Therapy	Sitting		

10. Does your pain interrupt your sleep? ____

How often? ____

11. Circle any of the following that you have tried to relieve your pain.

Acupuncture	Biofeedback	Counseling	Massage	Physical Therapy	Traction
Rest	Chiropractor Manipulation	Hypnosis	Pain Blocks	TENS unit	

Other: _________________ _______________________ _______________________

12. Have you ever had any pain blocks or cortisone (steroid) injections done for your pain? ___________

If yes, when? _______________ By whom? ___________________________

Did they help? ___________________ If yes, for how long? ____________________

13. List any <u>pain</u> medications you have tried and their effect on your pain:

Medication	**Dosage**	**Effect on Pain** { **No Improvement** / **Slight Improvement** / **Significant Improvement**

14. Have you had any of the following tests done for this condition?

		Date	**Where**
X-rays			
MRI			
EMG			
Myelogram			
CT Scan			
Bone Scan			
Other			