Brian Siegel, MD
Advanced pain relief to enhance your life

Out Patient Pain Questionnaire

Referring Physician_____**City**_____

Family Physician_____**City**_____

Brief Description of Pain Complaint:_____
_____

1. When did your pain start?_____

2. How did your pain start?_____

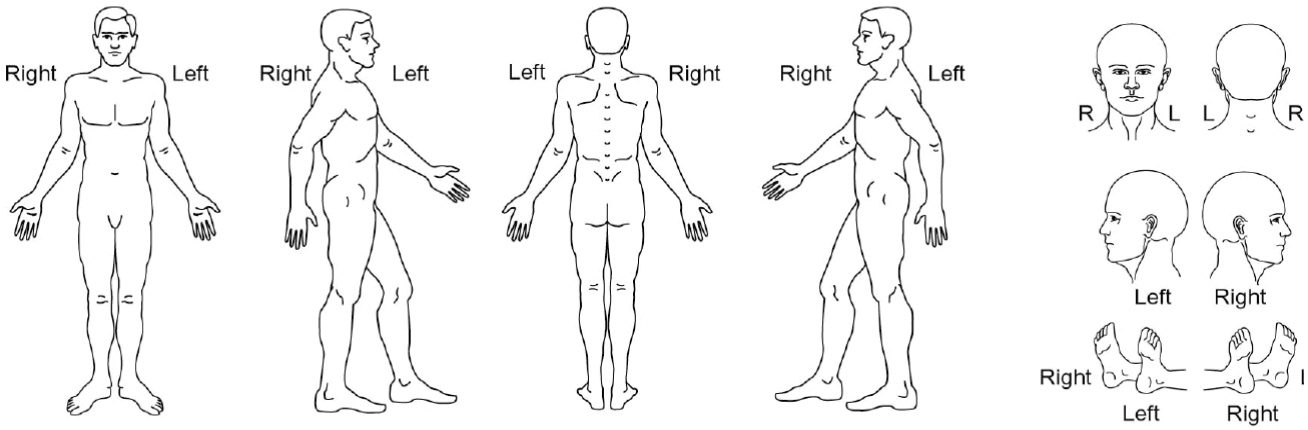
3. Rate your pain by circling the number that best describes your pain right now.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Goal of acceptable level of pain:

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Shade on the diagram your painful areas



5. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

6. Which of the following best describes the duration of your pain?

❑ Constant ❑ Rhythmic ❑ Intermittent
❑ Brief ❑ Momentary ❑ Transient

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7. Is your pain associated with any of the following?

❑ Numbness ❑ Tingling, pins and needles ❑ Increased sweating
❑ Weakness ❑ Coldness ❑ Skin discoloration
❑ Muscle spasm

8. Does your pain interfere with:

❑ Socialization ❑ Relations with other people ❑ Sexuality
❑ Work ❑ Enjoyment of life ❑ Moods
❑ Walking

9. What makes your pain worse?

❑ Sitting ❑ Standing ❑ Twisting ❑ Lying down
❑ Walking ❑ Physical activity ❑ Riding in a car

10. What makes your pain better?_____

11. Are you undergoing physical therapy and if so where? _____

12. Check the box if you have had any of the following:

❑ X –rays ❑ Myelogram ❑ MRI ❑ Cat Scan
❑ EMG ❑ Nerve conduction ❑ Bone Scan
Where were these studies performed?_____

11. Have you ever had any of the following for pain relief?

❑ Trigger Points ❑ Steroid injections ❑ Acupuncture ❑ Heat
❑ Traction ❑ Psychotherapy ❑ Biofeedback ❑ Tens
❑ Relaxation ❑ Hypnosis ❑ Distraction ❑ Cold Compresses

12. Do you have any of the following?

❑ Headaches ❑ Stomach Pain ❑ Chest Pain
❑ Vision Problems ❑ Nausea ❑ Shortness of Breath
❑ Hearing Problems ❑ Vomiting ❑ Urinary Problems
❑ Dizziness ❑ Constipation ❑ Rashes
❑ Difficulty Swallowing ❑ Diarrhea ❑ Swollen Joints
❑ Chronic Fatigue

13. How do you sleep? **Food intake?** **Activity?**

Good__ Fair __ Poor__ Good__ Fair__ Poor__ Good__ Fair__ Poor__

14. List all current medications and their doses:

_____
_____

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Domestic Situation

With whom do you live?_____

Are there any substance abuse issues in the household? Yes __ No __

If yes, please explain_____

Are you able to take care of yourself? Yes __ No __

If not, please enter name of caregiver_____

Work History

Job Years Worked Why did you leave?

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes __ No __

If yes, please explain_____

Substance Use

Do you have a family history of drug or alcohol abuse? Yes __ No __
Alcohol
Illegal Drugs
Prescriptions

Do you have a personal history of substance abuse? Yes __ No __
Alcohol
Illegal Drugs
Prescriptions

Age (Mark box if 16-45)

Do you have a history of preadolescent sexual abuse Yes __ No __

Do you have a history of psychological disease Yes __ No __
(i.e. Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia_

Do you presently smoke cigarettes or use tobacco in any form? Yes __ No __
If not, did you ever smoke cigarettes or use tobacco in any form? Yes __ No __
How many packs do (did) you smoke a day? _____ For how many years?_____

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