The Center for Pain Medicine
Pain Questionnaire – Initial Visit

Name: (last) ______________________ (first) ______________________ (middle) ___________

Date: __________________________ DO YOU HAVE AN ALLERGY TO LATEX PRODUCTS

_______ YES _______ NO

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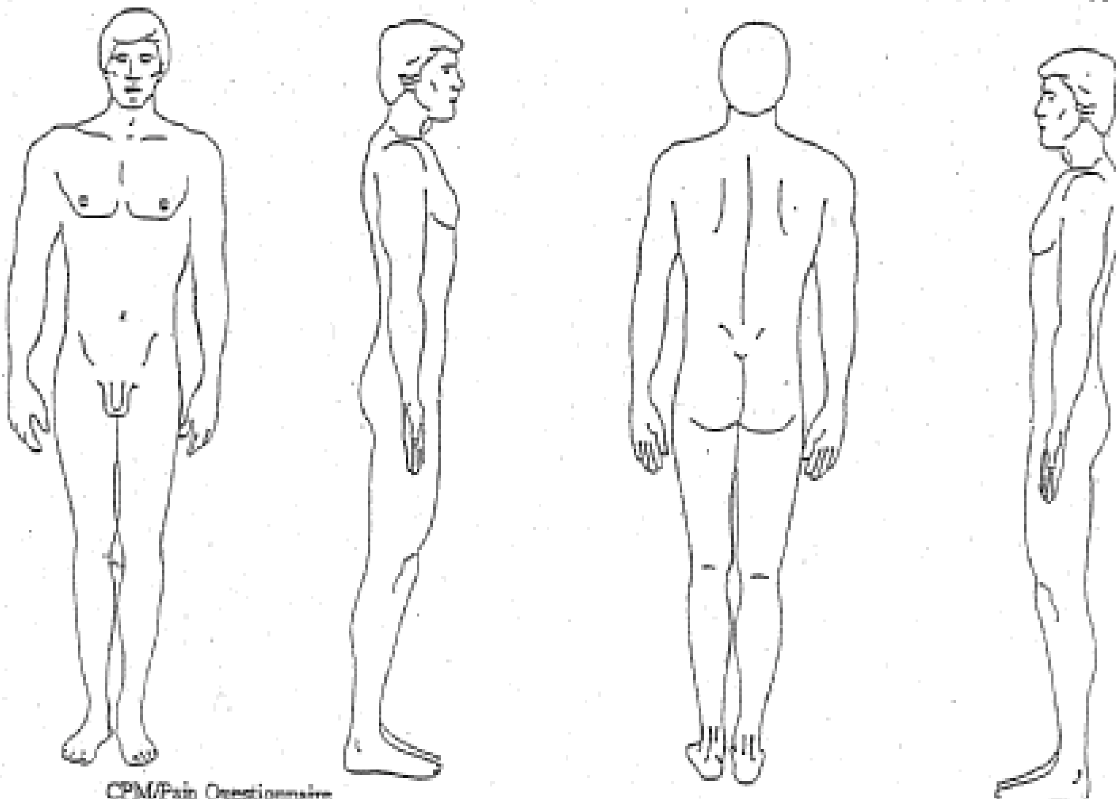
1) Where is your pain located? (Circle areas)

1	Low back	14	Left ankle or foot
2	Mid back	15	Right ankle or foot
3	Upper back	16	Left shoulder
4	Neck	17	Right Shoulder
5	Chest	18	Left Arm
6	Abdomen	19	Right Arm
7	Groin	20	Left hand or wrist
8	Left buttock	21	Right hand or wrist
9	Right buttock	22	Head
10	Left thigh	23	Face
11	Right thigh	24	Pelvic
12	Left calf	25	Rectal
13	Right calf	26	Vaginal

Other: ____

2) Please indicate on this diagram where your pain occurs by shading the painful area(s)



EMORY HEALTHCARE

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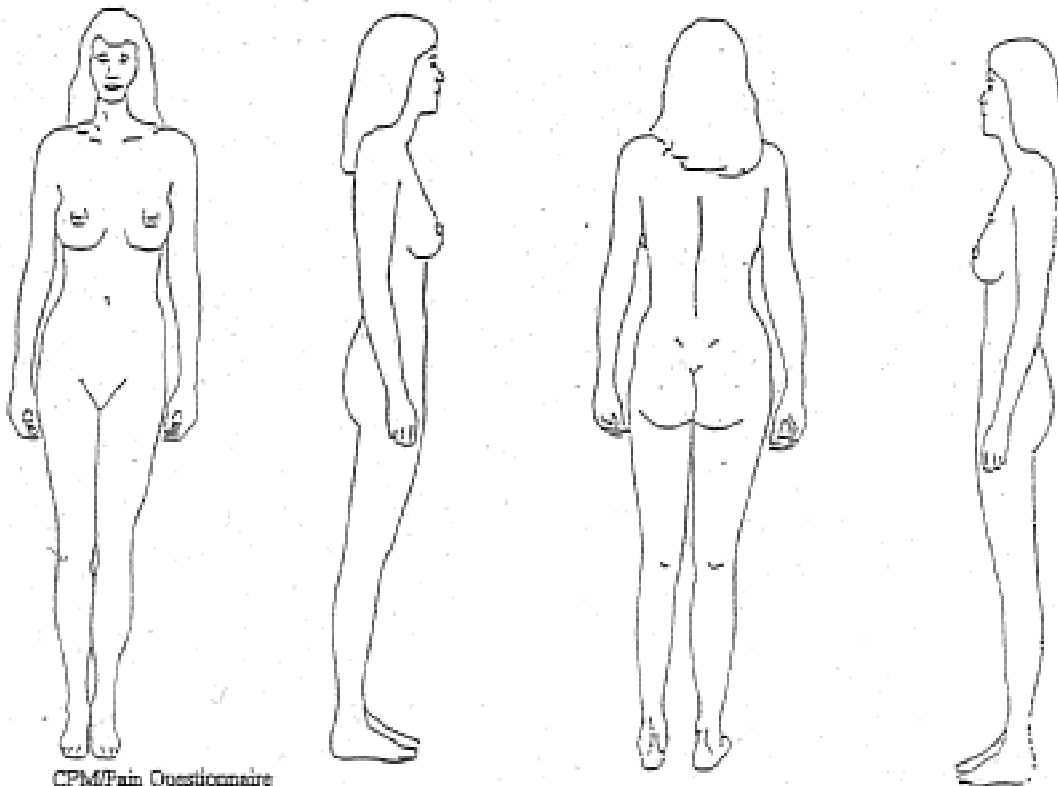

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3) Using the following scales to rate your pain, place a mark on each of the following lines between the two choices which most closely reflects your feelings:
Your Pain at it worst:
No pain ____unbearable pain
Your pain at its least severe:
No pain ____unbearable pain
Your pain as it usually is:
No pain ____unbearable pain
Your pain as it is right now:
No pain ____unbearable pain

4) Would you describe your pain as: (Circle one)

Burning?	Yes	No
Sharp?	Yes	No
Aching?	Yes	No
Throbbing?	Yes	No
Shooting?	Yes	No

Other (describe) ____

5) Which statement best describes your pain?
1_____Always present, always the same intensity
2_____Always present, intensity varies
3_____Usually present but have short periods without pain
4_____Often present, but have pain free periods lasting for one to several hours
5_____Often present, but am pain free for most of the day
6_____Ocaisionally present…have pain once to several times per day, lasting a few minutes up to an hour
7_____Ocaisionally present for brief periods, a few seconds to few minutes
8_____Rarely present…have pain every few days or weeks

6) What time of the day is your pain worse? (Check all that apply)
1_____Morning, on arising
2_____Later in the morning
3_____Aftrenoon
4_____Evening
5_____Bedtime
6_____Night (during usual sleeping hours)
7_____Pain always the same

7) Do you have? (Circle all that apply)

Numbness?	Tingling?	Pins and Needles
Weakness?	Coldness?	Increased Sweating
Muscle Spasm?	Tightness?	Skin Discoloration
Bowel or bladder problems		

8) Circle any of the following activities that make your pain worse:

Coughing or Sneezing	Sitting	Standing
Lying Down	Walking	Physical Activity
Sexual Activity	Other (describe) ______________________________	

9) Circle any of the following activities which make your pain better

Relaxation	Sitting	Standing
Lying Down	Alcoholic Drinks	Sexual Activity
Heat	Medicines	Walking

Other (describe) ____

10) Nothing I do makes my pain feel better (Circle One) True False

11) Does pain interrupt your sleep? (Circle one)

1_____Not at all
2_____Once per night
3_____Twice per night
4_____Three timer per night
5_____More than three times per night

12) When did you first notice your pain? (mo) __________(day)___________(yr)____

13) Under what circumstances did your pain begin? (check one)

1_____Accident at work
2_____Accident at home
3_____At work, but not an accident
4_____Pain just began, no reason
5_____Motor vehicle accident
6_____Following surgery
7_____Following illness
8_____Other (describe) ____

14) If pain began at work, please list the following:
Place of employment when pain began ___________________________________
Date of injury (mo)____________(day)______________(yr)_________________
How long had you been employed there? (yrs) ___________ (mos) ___________
Type of work? ____

15) If you were injured at work, describe how: (Check one)
1_____Fall
2_____Lifting Object
3_____Pushing
4_____Struck by falling object
5_____Struck by object
6_____Injury from repetitive activity
7_____Other (describe) ______________________
____

16) If injury resulted from motor vehicle accident, were you: (Check one)
1_____Driving automobile/truck
2_____Automobile/truck passenger
3_____Driving motorcycle
4_____Motorcycle passenger
5_____Pedestrian
6_____Describe details ____

17) When did you first see a doctor for the pain you have now?
(mo)________________(day)___________________(yr)___________________

18) Have you ever been hospitalized for your pain? (Circle One) Yes No

If yes, please list:

Hospital	Dates Admitted
___________________________________	________________________
___________________________________	________________________
___________________________________	________________________

19) Approximately how many physician visits have you had for your pain in the last year? ____

20) How many visits for pain to other health care professionals (physical therapist, occupational therapist, chiropractor, acupuncturist, etc.)? ___________________

21) Have you had any of the following? (Check all that apply)

1_____X-rays
2____Myeleogram
3_____EMG
4_____Bone scan
5_____MRI scan
6_____CAT Scan
7_____Other (describe) ____________________
____

22) Have you had surgery for pain?

1_____No- I have not had surgery
2_____Yes – 1 operation
3_____Yes – 2 operations
4_____Yes – 3 operations
5_____Yes - 4 or more operations

Please list:

Operation	Hospital	Date	Surgeon

23) Have you had nerve blocks (injections0 for pain relief? (Circle one)

Yes No

If yes, name the doctor who performed the blocks ___________________________

Did the blocks relieve the pain? (Circle one) Yes No

24) How long did the block(s) give you relief? (Circle one)

1_____Less than one day
2_____A few days
3_____ A few weeks
4_____More than a month

Circle any of the following treatments you have had fro pain relief?
Did it help your pain (circle yes or no)

Hypnosis?	Yes	No
Biofeedback?	Yes	No
TENS unit?	Yes	No
Acupuncture?	Yes	No
Chiropractic treatment?	Yes	No
Heat Therapy?	Yes	No
Bed rest?	Yes	No
Traction?	Yes	No
Osteopathic Treatment?	Yes	No
Psychotherapy/Psychiatry	Yes	No
Other: __________________	Yes	No

25) Since your pain began, has it? (Check one)
__________increased? __________decreased? _________stayed the same

26) Rate your ability to cope with your pain by making a mark on the line below between the two choices which most closely reflects your feelings.
Totally unable Cope
To cope____very well

The following questions ask you to rate the frequency in which you take part in various activities. Please make a mark on the line between the two choices which closely reflects your feelings.

27) How often do you take part in social activities now?
Never ____Very often

How often did you take par tin social activities before your pain began?
Never ____Very often

Does your pain prevent you from taking part in social activities? (Circle one)
Yes No

28) How often do you take part in recreational activities now? (Sports, fishing, movies, ballgames, concerts, etc.)
Never ____Very often

How often did you take part in recreational activities before your pain began?

Never ____Very often

Does pain prevent you from taking part in recreational activities? (Circle one)
Yes No

29) How often do you have sexual activity now?
Never ____Very often

How often did you have sexual activity before your pain began?
Never ____Very often

Does pain prevent you from taking part in sexual activity? (Circle one)
Yes No

30) How many hours do you sleep per 24 hour day, average? _____________hours

How many hours per 24 hour day did you sleep before your pain began?
_____hours

When do most of your sleeping problems occur? (Check all that apply)
1_____as I am trying to get to sleep
2_____after I have been sleeping a while
3_____1-2 hours before I have to get up

31) How much time do you spend per 24 hour day in the following activities?
(Indicate number of hours or minutes in blank next to activity)

Activity	**Hours**	**Minutes**
Sitting	______	______
Lying down, but not sleeping	______	______
Walking	______	______
Exercising	______	______
Working around the house (Gardening Cleaning, washing car, etc.)	______	______

32) Has your appetite changed since your pain began? (Circle one) Yes No
If yes, has it? (Circle one) Increased Decreased

33) Have you gained weight? (Circle one) Yes No
If you gained weight, how much?_ _______________pounds

34) Have you lost weight? (Circle one) Yes No
If you lost weight, how much? ___________________pounds

35) What is your occupation? (Circle one)

Academic	Medical	Office/Secretarial
Civil service (police, fire, etc)	Military	Factory Work
Construction	Other-Labor	Truck/Bus Driver
Homemaker	Student	Retired
Farmer	Other: ____________________________	

Specifically what do you do/did at work?
____
____
____

Place of employment (presently) ____

36) Are you employed now? (Check one)
1_____ Yes, full time
2_____Yes, full time with restrictions
3_____Yes, part time
4_____Yes, part time with restrictions
5_____On sick leave
6_____No, but not because of pain
7_____No, unable to work because of pain

37) Are you self-employed? (Circle one) Yes No

38) If you are working with restrictions, what are they? ________________________
____

39) If you are working, when was your last date of employment?
(mo) _________________________(day) ________________________(yr) ________

40) Does/Did your job involve any of the following activities? (Circle one)

Sitting	none	some	a great deal
Standing	none	some	a great deal
Walking	none	some	a great deal
Light lifting	none	some	a great deal

Heavy lifting	none	some	a great deal
Bending	none	some	a great deal
Pushing	none	some	a great deal
Driving	none	some	a great deal
Repetitive activity	none	some	a great deal
Other heavy work	none	some	a great deal

Describe: ____

Did you find your job satisfying? (Place a mark on each line between the two choices which most closely describes your feelings)

Not at all satisfying ________________________________Very satisfying

Do you feel your job was financially satisfying?

Not at all satisfying ________________________________Very satisfying

Did you stop working because of your pain? (Circle one) Yes No

Do you feel you can return to work? (Circle one) Yes No

If no, please explain: ____

____

41) What is your level of education? (Check one)

________ no formal education
________ some formal education, but did not graduate from high school
________ graduated high school
________ some college level course work, did not graduate
________ graduated college
________ graduated from vocational/technical school
________ post graduate degree

42) Have you received financial compensation related to your pain? (Circle one)

Yes No

If yes, was payment a lump sum?

Yes No

Are you receiving continued financial support related to your pain?

Yes No

If yes, who is providing payments?

Workers Compensation
A private insurance company
Social Security (SSI)
Social Security (SSDI)
WIC
Other ___________________________________

43) If you are receiving financial compensation do you feel it is satisfactory? (Make a mark on the line between the two choices which most closely reflects your feelings)

Not at all Very
Satisfactory ____satisfactory

44) Are you now bringing lawsuit because of your pain? (Circle one)
Yes No

45) Have already sued for compensation? (Circle one)
Yes No

46) Are you planning to sue because of your injury? (Circle one)
Yes No

47) Do you smoke? (Check one)
____not at all
____former smoker
____less than ½ - 1 pack per day (cigarettes)
____1-2 packs per day (cigarettes)
____2 or more packs per day (cigarettes)
____cigars
____pipes

How many years have you been smoking?
____

48) Do you drink alcohol? (Check one)
1. ____________ not at all
2. ____________ occasional social drink
3. ____________ regularly (1-3 drinks per day)
4. ____________ regularly (4 or more drinks per day)

49) If you drink alcohol, do you drink or relieve pain? (Circle one)
Yes No

50) If you drink alcohol, do you drink to help you sleep? (Circle one)

Yes No

51) Have you had any of the following conditions? (Circle one)

Condition		
Epilepsy, seizures?	Yes	No
Bronchitis, other lung disease?	Yes	No
Thyroid disease?	Yes	No
Jaundice, liver disease?	Yes	No
Psychiatric disorder?	Yes	No
Tuberculosis?	Yes	No
Heart disease?	Yes	No
High blood pressure?	Yes	No
Kidney disease?	Yes	No
Bladder problems?	Yes	No
Discharge from the urethra/penis?	Yes	No
Bowel problems?	Yes	No
Hearing problems?	Yes	No
Visual problems?	Yes	No
Stroke?	Yes	No
Diabetes?	Yes	No
Ulcers, other stomach problems?	Yes	No
Skin rash?	Yes	No
Joint disease, arthritis?	Yes	No
Drug allergies?	Yes	No

Other ____

52) Have you been hospitalized for medical problems other than your pain?
(Excluding childbirth) (Check one)

1. ___________ never
2. ___________ once
3. ___________ twice
4. ___________ three times
5. ___________ four or more times

Please list:

Date hospitalized	Hospital	Medical Problem
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

53) Before your pain began, did you consider yourself to be: (Make a mark on each line between the two choices which most closely reflects your feelings)

Frequently ill ____ Perfect Health
Extremely tired ____ Very energetic

54) Do you consider yourself to be illness prone? (Circle one)
Yes No

55) Have you ever had psychological or psychiatric treatment? (Circle one)
Yes No

56) Are you? (Check one)
1. __________ Married
2. __________ Never married
3. __________ Divorced/Separated
4. __________ Widowed

57) Do you live? (Check one)
1 _____ Alone
2 _____ With husband/wife/significant other
3 _____ With Children
4 _____ With husband/wife and children
5 _____ With other relatives
6 _____ With friend(s)/roommate

58) Do you have close family members with chronic (long-term) pain problems? (Check one)
1. _______ No
2. _______ Yes, husband/wife/significant other
3. _______ Yes, sister/brother
4. _______ Yes, father/mother
5. _______ Yes, son/daughter

59) Do you have close family members with chronic (long-term) illness? (Check one)
1. ________ No
2. ________ Yes, husband/wife/significant other
3. ________ Yes, sister/brother
4. ________ Yes, father/mother
5. ________ Yes, son/daughter

60) If you are married or have a significant other, please use the rating scales provided to describe your relationship with your significant other. (Make a mark on the lines between the two choices which most closely reflects your feelings.)

Relationship before pain began:
Poor ____ Excellent

Relationship now:
Poor ____ Excellent

61) Do you take medicines for pain relief? (Check one)

1. _________ No
2. _________ Yes, less than one time per week
3. _________ Yes, several times per week
4. _________ Yes, one or two times per day
5. _________ Yes, three or four times per day
6. _________ Yes, five or more times per day

62) If you take medications for pain, do you take it?

1 _________ When needed for pain
2 _________ Regularly, by the clock

63) Please list all pain medications you are currently taking:

Medication	Amount	Frequency

64) On the average, does the pain medicine you take: (Check one)

1. ______ always take the pain away
2. ______ always make the pain less
3. ______ usually take the pain away
4. ______ usually make the pain less
5. ______ provide little, if any, relief
6. ______ do not take pain medicine

65) How long does the pain medicine provide relief? (Check one)

1 ______ less than one hour
2 ______ 1-2 hours
3 ______ 2-4 hours
4 ______ 4-6 hours
5 ______ more than 6 hours
6 ______ do not take pain medicine

66) Do you take other medicines, even if not for pain? (Circle one)

Yes No

If yes, please list:

Medication	Amount	Frequency

67) Do you feel you are helpless to change your present condition? (Make a mark on the line between the two choices which most closely reflects your feelings)

Always helpless ____ Never helpless

68) Do you feel your present pain condition is hopeless? (Make a mark on the line between the two choices which most closely reflects your feelings)

Very hopeless ____ Not at all hopeless

What do you hope to gain from your treatment here?

____

____

____

____

____

Thank you for completing this questionnaire. _