Pain Management Established Patient Questionnaire

Please answer the following questions so we may best serve you for this appointment.

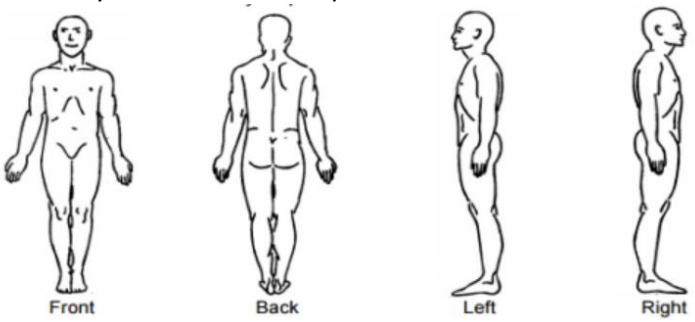
Name:	Phone:
Date of Birth:	Pharmacy:

1. Please select only the area(s) below where you have your most significant pain: ☐ Neck Only ☐ Neck, Shoulder(s), and Arm(s) ☐ Back Only ☐ Back, Buttock, and Leg(s) ☐ Buttock Only ☐ Groin Only ☐ Side of the Hip Only ☐ Other If different from above, please list pain location(s):

_____

2. If you indicated multiple locations, which **one** location is the absolute worst? _____

2a. Please circle the area of the body that has the most pain:



2a. If you indicated **Neck, Shoulder and/or Arm**, please note what percentage of pain is in your: Neck_____% Shoulders/Arms_____% *(Total = 100%)*

2b. If you indicated **Back, Buttock and/or Leg**, please note what percentage of pain is in your: Back_____% Buttock/Legs_____% (*Total = 100%)*

3. How do you describe your pain? ☐ Aching ☐ Burning ☐ Dull ☐ Numbing ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Spasming ☐ Squeezing ☐ Pressing

4. What is the frequency of your pain? ☐ It comes and goes ☐ Is constant (sometimes mild and sometimes severe) ☐ Is constant (always severe)

5. The intesity of pain is generally assessed with a rate from 0 to 10. (0 = No pain at all and 10 = worst pain imaginable) How would you rate your pain? At its Best: _____ At its Worst: _____ On Average: _____

6. How long have you had this pain? _____

7. Have you experienced any of the following associated symptoms since your pain started? ☐ Arm Weakness If yes, which arm _____ ☐ Arm Numbness If yes, which arm _____ ☐ Leg Weakness If yes, which leg _____ ☐ Leg Numbness If yes, which leg _____ ☐ Incontinence Bladder ☐ Incontinence Bowel

8. Please indicate if the following activities make your pain worse, better, or no affect. (Select only those that apply.)

Activity	Better	Worse
Laying Down or Resting	☐	☐
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Lifting	☐	☐
Bending	☐	☐
Exercise	☐	☐
Sexual Activity	☐	☐
Other:	☐	☐

9. Have you had injections in our clinic? ☐ Yes ☐ No If yes, did the injections help? ☐ Yes ☐ No

9a. If it helped, did it help more than 50%? ☐ Yes ☐ No What percent help did you get? _____

10. Have you had any side effects from any medication we prescribed you? ☐ Yes ☐ No

10a. If yes, which medication? _____

11. Are you taking any new medications for your pain? ☐ Yes ☐ No

11a. If yes, which ones? _____

12. Have you had Physical Therapy within the past 6 months? ☐ Yes ☐ No

12a. If yes, when? _____

13. Since your last visit, how would you assess the follow:

Activity Type	Better	Worse	Same
Sleeping	☐	☐	☐
Relationships	☐	☐	☐
Mood	☐	☐	☐
Pain level	☐	☐	☐
Overall Function	☐	☐	☐