McLaren- Lapeer Region
LAPEER, MI 48446

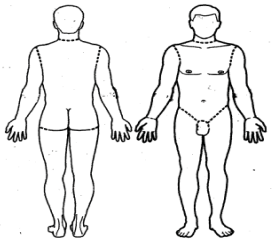
***PLEASE FILL IN BOTH SIDES** **PAIN CLINIC HISTORY QUESTIONNAIRE**

Patient Name:_____ Date of Birth:_____ Age:_____
Family Physician:_____ Referring Physician:_____
How pain problem started:_____

CHECK ALL THAT APPLY:

☐ Neck
☐ Low back
☐ Upper extremity
☐ Lower extremity
☐ Upper back

PAIN LOCATION



☐ Mid back
☐ Hand
☐ Foot
☐ Headaches
☐ Pelvis/Abdomen

HOW LONG:

☐ _____Years
☐ _____Month
☐ _____Weeks
☐ _____Days

Any initiating event (before pain problems started): ☐ Accidents ☐ Fall ☐ Injury ☐ Others: _____

PAIN SEVERITY: In a scale of 0 to 10; 0 is no pain and 10 is maximum pain one can imagine
At present (0-10 pain scale):_____ Usually at (0-10 pain scale):_____ Range (lowest to highest):_____

TYPE OF PAIN: ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Pressing ☐ Burning ☐ Hot ☐ Spasm
☐ Cramping ☐ Cold ☐ Squeezing ☐ Lacerating ☐ Electric ☐ Pinching ☐ Tingling ☐ Penetrating ☐ Pressure
☐ Other: _____

PAIN IS INCREASED BY: ☐ Physical activity ☐ Standing ☐ Walking ☐ Sitting ☐ Bending forward and or backward ☐ Driving
☐ Turning ☐ Lifting ☐ Reaching ☐ Stress ☐ Sneezing ☐ Coughing Other:_____

PAIN IS DECREASED BY: ☐ Never ☐ Resting ☐ Lying down ☐ Relaxing ☐ Sitting ☐ Sleep ☐ Medication ☐ PT
☐ Manipulation ☐ Others:_____

DOES THE PAIN MAKE YOU FEEL: ☐ Annoyed ☐ Miserable ☐ Unbearable ☐Intense ☐ Troublesome ☐ Afraid ☐ Frightened
☐ Terrified ☐ Dreadful ☐ Insecure

DO YOU HAVE/FEEL: ☐ No appetite ☐ Loss of sleep ☐ Feeling of hopelessness ☐ Loss of energy ☐ Lack of interest
SENSORY LOSS (any numbness and or tingling, any heat or cold problems): ☐ Yes ☐ No If yes, where:_____
ARM OR LEG WEAKNESS: ☐ Yes ☐ No If yes, where:_____
ANY BLADDER OR BOWEL CONTROL PROBLEMS: ☐ Yes ☐ No
ARE YOU USING ANY: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Brace ☐ Collar ☐ None

CURRENT PAIN MEDICATION:

NAME:	FREQUENCY	TOTAL PILLS/DAY	DOES IT HELP/ NO HELP/ SOME/ GOOD/ VERY GOOD/

MEDICATIONS USED IN THE PAST: ☐ Tylenol ☐ Motrin ☐ Aleve ☐ Naprosyn ☐ Steroids ☐ Lidoderm
☐ Elavil ☐ Vicodin ☐ Darvocet ☐ Norco ☐ Percocet ☐ Oxycontin ☐ MS Contin ☐ Fentanyl patch
☐ Morphine ☐ Dilaudid ☐ Methadone ☐ Lyrica ☐ Neurontin ☐ Patch/Onitment ☐ Others:_____

ANY PHYSICAL THERAPY? ☐ Yes ☐ No If yes, was it helpful: ☐ Yes ☐ No TENS UNIT: ☐ Yes ☐ No
Have you been seen by any Neurologist, Neurosurgeon or Orthopedic surgeon?_____
Have you been seen by any other pain physicians: ☐ Yes ☐ No, if yes, where:_____
List pain procedures/shots in the past:_____
ALLERGY:_____
_____

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LIST ALL MEDICATIONS (except pain medication):_____
_____
_____
_____

BLOOD THINNERS: ☐ Yes ☐ No if yes, please list: ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Aspirin ☐ Pradaxa
☐Other:_____
_____

GENERAL HEALTH HISTORY: (CHECK ALL THAT APPLY)

☐ Coronary artery disease	☐ Obstructive sleep apnea (CPAP, BiPAP)	☐ Anemia	☐ Hypothyroid
☐ Heart attack, Angina		☐ Stroke	☐ Jaundice
☐ Hypertension	☐ Asthma	☐ Kidney problems	☐ Hepatitis A, B, C
☐ High cholesterol	☐ COPD/Emphysema	☐ Migraines	☐ Cirrhosis
☐ Hearing problems	☐ Diabetes: Insulin &/or pills	☐ Hypothyroid	☐ Peptic ulcer disease
			☐ Headaches

ANY SURGERY IN THE PAST: (CHECK ALL THAT APPLY)

☐ Appendectomy	☐ Hysterectomy	☐ Tonsil & Adenoidectomy	☐ C-section
☐ EGD	☐ Lumbar spine surgery	☐ Cataract Surgery	☐ Tubal Ligation
☐ Colonoscopy	☐ Cervical spine surgery	☐ Gall Bladder	☐ Pacemaker/Defibrillator
			Other:_____

HISTORY OF A TUMOR OR CANCER: ☐ Yes ☐ No If yes, where:_____
Chemo, Radiation, Surgery:_____Any metastasis/spreading: ☐ Yes ☐ No

WORK HISTORY: Years worked:_____ Why did you leave:_____
Job:_____
If not working, last time worked?_____

DOMESTIC SITUATION: With whom do you live?_____
Are there any substance abuse issues in this household? ☐ Yes ☐ No If yes, what?_____
Are you able to take care of yourself? ☐ Yes ☐ No Married: ☐ Yes ☐ No Children: ☐ Yes ☐ No Ages:_____

SUBSTANCE USES:
Tobacco: ☐ Yes ☐ No Quit: ☐ Yes ☐ No When:_____ How long:_____ Pack per day:_____
Alcohol: ☐ Yes ☐ No Quit: ☐ Yes ☐ No When:_____ How long:_____ How often:_____
Marijuana: ☐ Yes ☐ No Quit: ☐ Yes ☐ No When:_____ How long:_____ How often:_____
Cocaine, Heroine, Amphetamines, Barbiturates or others:_____

LEGAL MATTERS: Are you presently involved in a lawsuit? ☐ Yes ☐ No If yes, please explain:_____
_____

FAMILY HISTORY:_____
_____

CHECK ALL THAT APPLY:

☐ Anemia	☐ Diarrhea	☐ Car Accident	☐ Chest pain
☐ Edema	☐ Weight gain	☐ Fracture: Leg or Arm	☐ Difficulty swallowing
☐ Cyanosis	☐ Weight loss	☐ Angina	☐ Chronic Fatigue
☐ Hiccup	☐ Jaundice	☐ Hearing problems	☐ Fall
☐ Shortness of Breath	☐ Confusion	☐ Vision Problems	☐ Sexually difficulty
☐ Nausea	☐ Headache	☐ Urinary problems	Other:_____
☐ Vomiting	☐ Lack of sleep	☐ Dizziness	_____
☐ Constipation	☐ Depression	☐ Rashes	_____
	☐ Bleeding disorder	☐ Stomach pain	

Patient Signature: _____ Date: _____Time:_____