



**COMPREHENSIVE PAIN QUESTIONNAIRE**

Please complete this form before your first appointment at Capstone Pain Management. Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g. Workmen's Compensation Claims).

**Date:** \_\_\_\_\_

**Name:**

\_\_\_\_\_ Last First Middle Initial

**Address:**

\_\_\_\_\_ Street Address

\_\_\_\_\_ City State Zip

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Referring MD:** \_\_\_\_\_

**Other Physicians currently involved in my care:** \_\_\_\_\_

**Sex:** M  F

**Age:** \_\_\_\_\_ **Race:**  Asian-American  African-American  
 White  Hispanic

**DOB:** \_\_\_\_\_  Other

**CHARACTERISTICS OF PAIN:**

What is the main problem for which you are seeking treatment?

\_\_\_\_\_  
How long have you had your current pain problem?  
\_\_\_\_\_ years \_\_\_\_\_ months

Currently my Pain Level is \_\_\_/10. At best my Pain Level is \_\_\_/10. At worst my Pain Level is \_\_\_/10.

**ONSET OF PAIN:** How did your current pain start?

- Injury at work
- Injury, not at work
- Motor vehicle accident
- Illness, non-injury
- Treatment caused (e.g. radiation, surgery, etc).
- Undetermined

If there was another cause not mentioned, what was it? \_\_\_\_\_

**SEVERITY OF PAIN:** In general, over the past month, the intensity of my pain has been:

- Mild  Moderate
- Moderate- Severe  Severe

**TIMING OF PAIN:** How often do you have your pain (please check one)?

- Constantly (100% of the time)
- Nearly constantly (60 to 95% of the time)
- Intermittently (30 to 60% of the time)
- Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst (please check one)

- Morning
- Afternoon
- Evening
- Night
- No typical pattern

**PAIN/SYMPTOM QUALITY:** How would you describe your pain (please check all that apply; if there is a dominant quality to your pain, please circle the appropriate term):

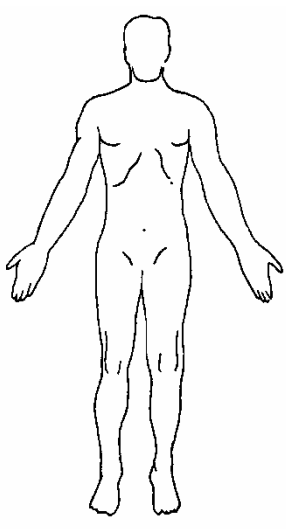
- burning       sharp       cutting       throbbing
- cramping       dull/aching       pressure
- shooting       other (describe) \_\_\_\_\_

Associated with pain, I feel the following (please check all appropriate terms):

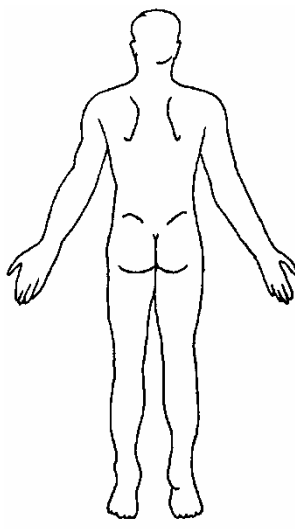
- Numbness      I feel these sensations in the  Same       Different areas      than the pain.
- Pins and needles      I feel these sensations in the  Same       Different areas      than the pain.

I have had weakness in my:      Upper extremities       Yes      Dropping objects?       Yes  
Lower extremities       Yes      Falling?       Yes  
Other (please describe) \_\_\_\_\_

**PAIN LOCATION:** please mark the location(s) of your pain on the diagrams above with an "X". If whole areas are painful, please shade in these areas.



*Front*



*Back*

**RELIEVING AND AGGRAVATING FACTORS:**

How do the following affect your pain (please check one for each item).

	<u>DECREASE</u>	<u>NO CHANGE</u>	<u>INCREASE</u>
<b>LYING DOWN</b>			
<b>STANDING</b>			
<b>SITTING</b>			
<b>WALKING</b>			
<b>EXERCISE</b>			
<b>RELAXATION</b>			
<b>COUGHING/SNEEZING</b>			
<b>URINATION</b>			
<b>BOWEL MOVEMENTS</b>			

I have \_\_\_\_ **had** - or- \_\_\_\_ **not had** a recent change in bowel or bladder habits.

Please describe recent changes \_\_\_\_\_

**ACTIVITIES AND YOUR PAIN:**

How many blocks can you walk?  Less than a block \_\_\_\_ Blocks (how many?)

How many minutes or hours can you sit? \_\_\_\_ Minutes (how many?) \_\_\_\_ Hours (how many?)

How many minutes or hours can you stand? \_\_\_\_ Minutes (how many?) \_\_\_\_ Hours (how many?)

How often during the day do you lie down because of pain?

- Never       Seldom       Sometimes       Often       Constantly

To assist walking, I use a:  Cane       Walker       Wheelchair       No assistance device

Are you **NOT** able to perform any of the following activities of daily living? (check all that apply)

- Going to work       Performing household chores       Doing yard work or shopping  
 Socializing with friends       Participating in recreational activities       Exercising

**PAIN TREATMENTS:** Please check your response to all the treatments you have tried.

<u>TREATMENT</u>	<u>NO RELIEF</u>	<u>MODERATE RELIEF</u>	<u>EXCELLENT RELIEF</u>
<b>SURGERY</b>			
<b>TRACTION</b>			
<b>NERVE BLOCK/INJECTION</b>			
<b>PHYSICAL THERAPY</b>			
<b>EXERCISE</b>			
<b>TENS</b>			
<b>HEAT TREATMENT</b>			
<b>ICE TREATMENT</b>			
<b>PSYCHOTHERAPY</b>			
<b>ACUPUNCTURE</b>			
<b>HYPNOSIS</b>			
<b>BIOFEEDBACK</b>			
<b>CHIROPRACTIC MANIPULATION</b>			



**PRIOR PAIN TREATMENTS:** please check all medications you have used in the past for treatment of pain. These are listed by class of medication.

- | <b>Opioids</b>  | <b>NSAIDs/TYLENOL</b>                        | <b>Muscle Relaxants</b>                    |
|---|--|--|
| <input type="checkbox"/> Hydrocodone (Vicodin)        | <input type="checkbox"/> Tylenol             | <input type="checkbox"/> Soma              |
| <input type="checkbox"/> Propoxyphene (Darvocet)      | <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Parafon Forte     |
| <input type="checkbox"/> Codeine                      | <input type="checkbox"/> Motrin              | <input type="checkbox"/> Flexeril          |
| <input type="checkbox"/> Fentanyl (Fentora/Duragesic) | <input type="checkbox"/> Naproxen            | <input type="checkbox"/> Baclofen          |
| <input type="checkbox"/> Hydromorphone (Dilaudid)     | <input type="checkbox"/> Daypro              | <input type="checkbox"/> Zanaflex          |
| <input type="checkbox"/> Morphine/MSContin            | <input type="checkbox"/> Salsalate/Trilisate | <input type="checkbox"/> Robaxin           |
| <input type="checkbox"/> Demerol                      | <input type="checkbox"/> Feldene             | <input type="checkbox"/> Skelaxin          |
| <input type="checkbox"/> Levodromoran                 | <input type="checkbox"/> Indocin             | <input type="checkbox"/> Valium (Diazepam) |
| <input type="checkbox"/> Methadone                    | <input type="checkbox"/> Lodine              |  |
| <input type="checkbox"/> Oxycodone (Percocet)         | <input type="checkbox"/> Orudis              |  |
| <input type="checkbox"/> Oxycontin                    | <input type="checkbox"/> Relafen             |  |
| <input type="checkbox"/> Oxymorphone (Opana)          |  |  |
| <input type="checkbox"/> Stadol                       | <input type="checkbox"/> Celebrex            |  |
| <input type="checkbox"/> Talwin                       | <input type="checkbox"/> Vioxx               |  |
| <input type="checkbox"/> Tramadol (Ultram)            | <input type="checkbox"/> Toradol             |  |

- | <b>ANTIDEPRESSANTS</b>                           | <b>OTHER</b>                      |                                    |  |
|--|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Elavil (amitriptyline)  | <input type="checkbox"/> Paxil    | <input type="checkbox"/> Neurontin | <input type="checkbox"/> Xanax/Ativan/Valium |
| <input type="checkbox"/> Pamelor (nortriptyline) | <input type="checkbox"/> Prozac   | <input type="checkbox"/> Lyrica    | <input type="checkbox"/> Tegretol            |
| <input type="checkbox"/> Desipramine             | <input type="checkbox"/> Serzone  | <input type="checkbox"/> Dilantin  | <input type="checkbox"/> Mexilitine          |
| <input type="checkbox"/> Imipramine (Tofranil)   | <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Depakote  | <input type="checkbox"/> Imitrex             |
| <input type="checkbox"/> Zoloft                  |                                   | <input type="checkbox"/> Klonopin  | <input type="checkbox"/> Ergotamine          |

**ALLERGIES:** Please indicate the names of any medications to which you are allergic:

\_\_\_\_\_

What type of reaction did you have? \_\_\_\_\_

I am allergic to contrast dye used for X-rays \_\_\_\_ Yes \_\_\_\_ No

**REVIEW OF SYSTEMS:** please check all items you feel are applicable to you:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Recent significant gain of weight: ____ pounds over ____ weeks/months/years |   |  |
| <input type="checkbox"/> Recent significant loss of weight: ____ pounds over ____ weeks/months/years |   |  |
| <input type="checkbox"/> Fever   |   |  |
| <input type="checkbox"/> Dizziness   |   |  |
| <input type="checkbox"/> Difficulty swallowing   | <input type="checkbox"/> Memory loss                | <input type="checkbox"/> Joint stiffness                   |
| <input type="checkbox"/> Double or blurry vision   | <input type="checkbox"/> Loss of consciousness      | <input type="checkbox"/> Decreased range of motion         |
| <input type="checkbox"/> Nausea  | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Difficulty walking                |
| <input type="checkbox"/> Vomiting  | <input type="checkbox"/> Easy or excessive bruising | <input type="checkbox"/> Muscle weakness                   |
| <input type="checkbox"/> Constipation  | <input type="checkbox"/> Easy or excessive bleeding | <input type="checkbox"/> Pain in extremity (specify) _____ |
| <input type="checkbox"/> Diarrhea  | <input type="checkbox"/> Rash                       | <input type="checkbox"/> Swelling (specify) _____          |
| <input type="checkbox"/> Difficulty initiating urine stream  | <input type="checkbox"/> Diabetes                   |  |
| <input type="checkbox"/> Genital pain  | <input type="checkbox"/> Adrenal disease            |  |
| <input type="checkbox"/> Chest pain  | <input type="checkbox"/> Hypothyroidism             |  |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Heart palpitations         |  |
| <input type="checkbox"/> Wheezing  | <input type="checkbox"/> Hyperthyroidism            |  |

**SOCIAL HISTORY:**

**EDUCATION:** Your highest education level achieved:

- Graduate or professional training
- College graduate
- Partial college training
- High school graduate
- GED or trade-technical school graduate
- Partial high school (10<sup>th</sup> grade through partial 12<sup>th</sup>)
- Partial junior high school (7<sup>th</sup> grade through 9<sup>th</sup> grade)
- Elementary school

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**EMPLOYMENT:** Your current or most recent occupation:

- Semi-skilled or unskilled (eg. Waitress, assembler)
- Skilled trade or clerical (eg. Carpenter, electrician, truck driver, secretary)
- Business executive or Managerial
- Professional (eg. Lawyer, teacher, nurse, physician, psychologist)
- Homemaker
- Other: please specify \_\_\_\_\_

**CURRENT EMPLOYMENT STATUS:** Please check one:

- Employed full-time
- Employed part-time
- Unemployed
- Retired
- Student
- Homemaker

If you are unemployed or employed part-time, is this due to your present pain condition?  Yes  No

If you are currently unemployed, indicate how long you have been off work: \_\_\_\_\_

**LEGAL ISSUES:** Please indicate any of the following claims you have filed related to your pain problem:

- Worker's compensation
- Personal Injury/Liability
- Social Security Disability Insurance (SSDI)
- Other insurance

**SLEEP DISTURBANCE:**

- Do you have difficulty falling asleep?  Yes  No
- Do you have difficulty remaining asleep?  Yes  No
- Are you ever awakened by pain?  Yes  No

If you use any sleep-aids, please specify \_\_\_\_\_

**FAMILY LIFE:** please specify living arrangements:

- Living alone
- Living with spouse/partner  Living with friends
- Living with spouse/partner and children  Living with other
- Living with children

**PSYCHOLOGICAL TREATMENT:**

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?  
 Yes  No

For what diagnosis were you treated? \_\_\_\_\_

When? \_\_\_\_\_

Please list your current or last therapists \_\_\_\_\_

- Have you ever considered suicide?  Yes  No When? \_\_\_\_\_
- Have you ever planned suicide?  Yes  No When? \_\_\_\_\_
- Have you ever attempted suicide?  Yes  No When? \_\_\_\_\_

**SUBSTANCE ABUSE:**

- Have you ever been a smoker?  Yes-Current  Yes- In past  No-Never
- If you smoke, how many packs per day? \_\_\_\_\_Packs per day
- For how many years did you smoke? \_\_\_\_\_Years

Do you have a history of alcoholism?  Yes  No  Current problem  
Have you abused prescription analgesics?  Yes  No  Current problem  
Cocaine or intravenous substance abuse?  Yes  No  Current problem

How many years has it been since you abused alcohol or drugs \_\_\_\_\_ years

If you have a history of alcoholism, have you ever been enrolled in Alcoholics Anonymous?  
 Yes  No When? \_\_\_\_\_

If you have a history of substance abuse, have you ever been in a detoxification program?  
 Yes  No When? \_\_\_\_\_

**FAMILY HISTORY:** Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

Condition: \_\_\_\_\_ Specific family member(s): \_\_\_\_\_  
Condition: \_\_\_\_\_ Specific family member(s): \_\_\_\_\_  
Condition: \_\_\_\_\_ Specific family member(s): \_\_\_\_\_  
Condition: \_\_\_\_\_ Specific family member(s): \_\_\_\_\_

**PHYSICAL EXAMINATION**

How much do you weigh? \_\_\_\_\_ pounds  
How tall are you? \_\_\_\_\_ feet \_\_\_\_\_ inches

**\*TO BE COMPLETED BY CAPSTONE PAIN MANAGEMENT SPECIALISTS STAFF \***

BP \_\_\_\_\_ HR \_\_\_\_\_

*Physical examination:*

**GENERAL:**  Alert and Oriented  Converses easily, no Confusion  Other \_\_\_\_\_

**HEENT:** Head:  Atraumatic  Normocephalic  Other \_\_\_\_\_

Pupils:  Equal, Round, Reactive and able accommodate  Other \_\_\_\_\_

Neck:  Supple without masses  Other \_\_\_\_\_

**Heart:**  Regular Rate & Rhythm  S1 S2 present  Other \_\_\_\_\_

**Lungs:**  Clear to auscultation bilaterally  Wheezes  Other \_\_\_\_\_

**Abdmen:**  Soft, non-tender, non-distended, I active bowel sounds  Other \_\_\_\_\_

**Skin :**  Normal  rash  erythema  scar location? \_\_\_\_\_

**Neuro:** Gait  Normal  Antalgic  Other: \_\_\_\_\_

Motor  Intact  Other: \_\_\_\_\_

Sensory  Intact to touch and pinprick  Other: \_\_\_\_\_

Reflexes  Normal  Reduced \_\_\_\_\_

**Musculoskeletal:**

Cervical  FROM  Decreased ROM Describe \_\_\_\_\_

Tenderness Describe \_\_\_\_\_

Spurlings  Right  Left

Shoulder  FROM  Decreased ROM Describe \_\_\_\_\_

Tenderness Describe \_\_\_\_\_

Thoracic  FROM  Decreased ROM Describe \_\_\_\_\_

Tenderness Describe \_\_\_\_\_

Lumbar  FROM  Decreased ROM Describe \_\_\_\_\_

Tenderness Describe \_\_\_\_\_

Straight leg raise  Right  Left

Kemps test  Right  Left

Sacroiliac  Tenderness  Right  Left Describe \_\_\_\_\_

Hip  Tenderness  Right  Left Describe \_\_\_\_\_

Knee  Tenderness  Right  Left Describe \_\_\_\_\_