

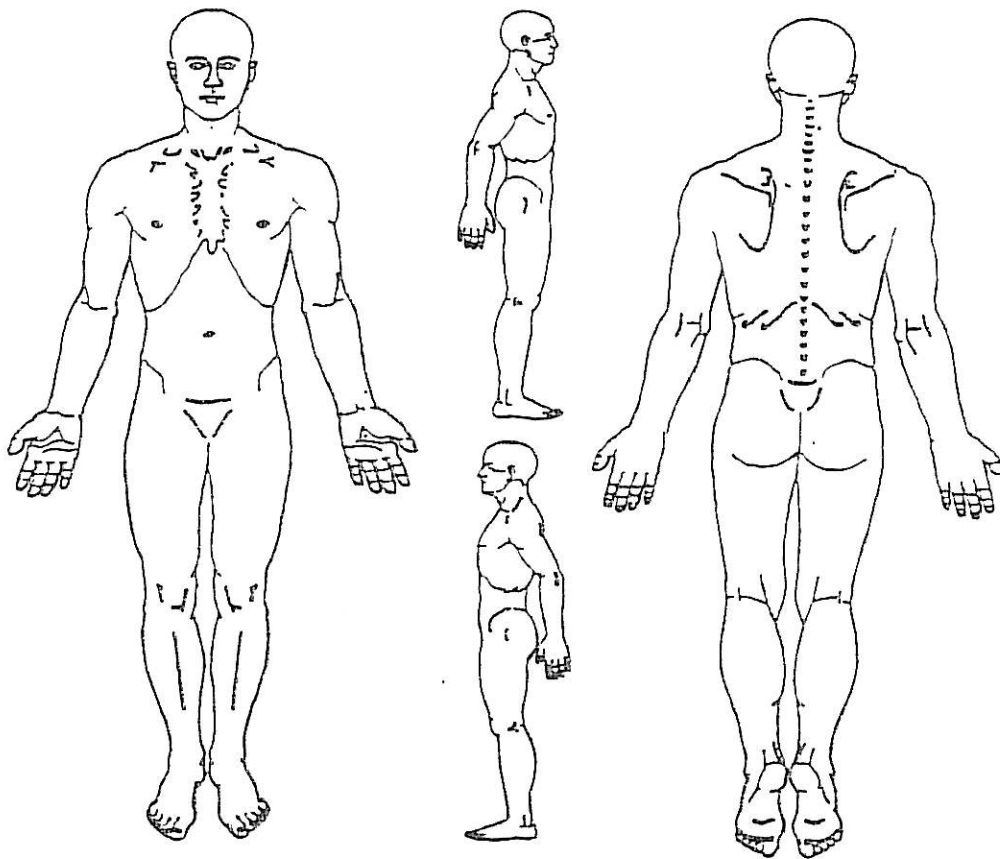
**INITIAL PAIN QUESTIONNAIRE**

Orthopedic Institute  
1044 SW 44<sup>th</sup> St.  
Oklahoma City, OK 73109  
405-631-4263  
Ht. \_\_\_\_\_ Wt. \_\_\_\_\_  
BP \_\_\_\_\_ HR \_\_\_\_\_

Name \_\_\_\_\_  
Date \_\_\_\_\_ Age \_\_\_\_ DOB \_\_\_\_\_  
Who referred you to the Center? \_\_\_\_\_

**CHIEF COMPLAINT:** Where are your main pain areas? \_\_\_\_\_

**INDICATE PAIN LOCATIONS:** Where does it hurt?



**PAIN HISTORY**

Circumstances of Onset

- Accident at work \_\_\_\_\_
- Accident at home \_\_\_\_\_
- Other accident \_\_\_\_\_
- Following illness \_\_\_\_\_
- Following Surgery \_\_\_\_\_
- Pain "just began" \_\_\_\_\_

Date of injury \_\_\_\_\_

Where were you working? \_\_\_\_\_

Why do you think you have pain? What do you think is wrong? \_\_\_\_\_

Do you have any numbness in your arms or legs? YES \_\_\_ NO \_\_\_ If Yes, where? \_\_\_\_\_

Do you have any tingling sensations in your arms or legs? YES \_\_\_ NO \_\_\_ If Yes, where? \_\_\_\_\_

Do you have any weakness in your arms or legs? YES \_\_\_ NO \_\_\_ If Yes, where? \_\_\_\_\_

Do you have incontinence of bowel? YES \_\_\_ NO \_\_\_

Do you have incontinence of bladder? YES \_\_\_ NO \_\_\_

Have you had any of the following done concerning your pain area?

X-rays YES \_\_\_ NO \_\_\_ if Yes, WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

CT-scan YES \_\_\_ NO \_\_\_ if Yes, WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

MRI scan YES \_\_\_ NO \_\_\_ if Yes, WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

Discography YES \_\_\_ NO \_\_\_ if Yes, WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

Have you seen any of the following for your pain?

	Name	Treatment Received	Date(s)	Helpful?
Acupuncturist	_____	_____	_____	_____
Anesthesiologist	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Neurologist	_____	_____	_____	_____
Neurosurgeon	_____	_____	_____	_____
Pain Management Physician	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Primary Care Physician	_____	_____	_____	_____
Psychologist/Psychiatrist	_____	_____	_____	_____
Rheumatologist	_____	_____	_____	_____
Other	_____	_____	_____	_____

What medications or other therapies (such as heat, TENS unit, Biofeedback, Ultrasound, etc.) have you ever tried for your pain)? (please indicate how helpful each has been and if there were any associated side effects)

Medication/Therapy	? Helpful	Side effects

If you have ever taken narcotics for your pain, please indicate approximate dates

Type of narcotic \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Type of narcotic \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**PAIN DESCRIPTION**

On a scale of 0-5, with 0=no pain and 5 = the worst pain imaginable, please rate:

	Your pain right Now (0-5)
	Your pain at its worst (0-5)
	Your pain at its least (0-5)

Does the severity of your pain vary according to time of day? \_\_\_\_\_

List specific activities which increase your pain

a) \_\_\_\_\_ c) \_\_\_\_\_

b) \_\_\_\_\_ d) \_\_\_\_\_

List specific activities or thing you can do which decrease your pain

a) \_\_\_\_\_ c) \_\_\_\_\_

b) \_\_\_\_\_ d) \_\_\_\_\_

**McGill Short Form Pain Questionnaire**

Please indicate degree that each of the following word descriptors apply to your pain.

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Throbbing	0) _____	1) _____	2) _____	3) _____
Shooting	0) _____	1) _____	2) _____	3) _____
Stabbing	0) _____	1) _____	2) _____	3) _____
Sharp	0) _____	1) _____	2) _____	3) _____
Cramping	0) _____	1) _____	2) _____	3) _____
Gnawing	0) _____	1) _____	2) _____	3) _____
Hot-burning	0) _____	1) _____	2) _____	3) _____
Aching	0) _____	1) _____	2) _____	3) _____
Heavy	0) _____	1) _____	2) _____	3) _____
Tender	0) _____	1) _____	2) _____	3) _____
Splitting	0) _____	1) _____	2) _____	3) _____
Tiring-exhausting	0) _____	1) _____	2) _____	3) _____
Sickening	0) _____	1) _____	2) _____	3) _____
Fearful	0) _____	1) _____	2) _____	3) _____
Punishing-cruel	0) _____	1) _____	2) _____	3) _____

Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

0 1 2 3 4 5 6 7 8 9 10  
not at all all of the time

Does your pain interfere with your ability to manage your personal grooming (bathing, dressing, combing your hair, etc.) ?

0 1 2 3 4 5 6 7 8 9 10  
not at all all of the time

Does your pain interfere with your ability to drive a car?

0 1 2 3 4 5 6 7 8 9 10  
not at all all of the time



Do you have allergies to any medications? YES \_\_\_\_\_ NO \_\_\_\_\_ If Yes, please write below

Medication	Type of reaction

Please list all past and present medical problems. (example - diabetes, high blood pressure, etc)

Medical Problem	Details

Please list previous surgeries

Surgery	Date	Details

**FAMILY MEDICAL HISTORY**

Family member	Age	Diseases	If disabled, cause	If deceased, cause of death

Are there any pain problems that run in your family? YES \_\_\_\_\_ NO \_\_\_\_\_

Are there other family members on disability for pain related problems? YES \_\_\_\_\_ NO \_\_\_\_\_

**PATIENT SOCIAL HISTORY**

Marital status: Single: \_\_\_ Married: \_\_\_ Separated: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_  
 Children : Ages \_\_\_\_\_ Living at home with you? YES \_\_\_ NO \_\_\_  
 Who else live with you at home? \_\_\_\_\_  
 Use of alcohol: Never: \_\_\_ Rarely: \_\_\_ Moderate: \_\_\_ Daily: \_\_\_  
 Use of tobacco: Never: \_\_\_ Previously, but quit: \_\_\_ Current packs per day: \_\_\_  
 Use of non-prescription drugs: Never: \_\_\_ Type/Frequency \_\_\_\_\_  
 Use of caffeine: Never: \_\_\_ Type/Frequency \_\_\_\_\_  
 Have you ever had a problem with dependency or abuse of prescription or Non prescription drugs? YES \_\_\_ NO \_\_\_  
 Have you ever been physically abused? YES \_\_\_ NO \_\_\_  
 Have you ever been sexually abused? YES \_\_\_ NO \_\_\_  
 Excessive exposure at home or work to: Fumes \_\_\_ Dust \_\_\_ Solvents \_\_\_ Particles \_\_\_ Noise \_\_\_  
 Occupation \_\_\_\_\_ Hours per day \_\_\_\_\_  
 Retired: YES \_\_\_ No \_\_\_ Disabled: YES \_\_\_ NO \_\_\_ Since when? \_\_\_\_\_  
 Are you involved in any litigation, workers compensation claim or disability claim? YES \_\_\_ NO \_\_\_

## REVIEW OF SYSTEMS:

### CONSTITUTIONAL SYMPTOMS

Good general health lately Yes \_\_\_ No \_\_\_  
Recent weight change Yes \_\_\_ No \_\_\_  
Fever Yes \_\_\_ No \_\_\_  
Fatigue Yes \_\_\_ No \_\_\_

### EYES

Eye disease or injury Yes \_\_\_ No \_\_\_  
Wear glasses/contact lenses Yes \_\_\_ No \_\_\_  
Blurred vision Yes \_\_\_ No \_\_\_  
Glaucoma Yes \_\_\_ No \_\_\_

### EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing Yes \_\_\_ No \_\_\_  
Earaches or drainage Yes \_\_\_ No \_\_\_  
Chronic sinus problem or rhinitis Yes \_\_\_ No \_\_\_  
Nose bleeds Yes \_\_\_ No \_\_\_  
Mouth sores Yes \_\_\_ No \_\_\_  
Bleeding gums Yes \_\_\_ No \_\_\_  
Sore throat or voice change Yes \_\_\_ No \_\_\_

### CARDIOVASCULAR

Heart trouble Yes \_\_\_ No \_\_\_  
Chest pain or angina pectoris Yes \_\_\_ No \_\_\_  
Palpitations Yes \_\_\_ No \_\_\_  
Exposure to TB? Yes \_\_\_ No \_\_\_  
Swelling of feet, ankles or hands Yes \_\_\_ No \_\_\_  
Murmurs Yes \_\_\_ No \_\_\_

### RESPIRATORY

Chronic or frequent coughs Yes \_\_\_ No \_\_\_  
Spitting up blood Yes \_\_\_ No \_\_\_  
Shortness of breath Yes \_\_\_ No \_\_\_  
Asthma or Wheezing Yes \_\_\_ No \_\_\_

### GASTROINTESTINAL

Loss of appetite Yes \_\_\_ No \_\_\_  
Nausea or vomiting Yes \_\_\_ No \_\_\_  
Frequent diarrhea Yes \_\_\_ No \_\_\_  
Painful bowel movements or constipation Yes \_\_\_ No \_\_\_  
Rectal bleeding or blood in stool Yes \_\_\_ No \_\_\_  
Abdominal pain Yes \_\_\_ No \_\_\_  
Peptic ulcer(stomach or duodenal) Yes \_\_\_ No \_\_\_  
Hepatitis Yes \_\_\_ No \_\_\_  
Pancreatitis Yes \_\_\_ No \_\_\_

### GENITOURINARY

Frequent urination Yes \_\_\_ No \_\_\_  
Burning or painful urination Yes \_\_\_ No \_\_\_  
Blood in urine Yes \_\_\_ No \_\_\_  
Incontinence or dribbling Yes \_\_\_ No \_\_\_  
Kidney stones Yes \_\_\_ No \_\_\_  
Sexual difficulty Yes \_\_\_ No \_\_\_  
Male – testicle pain Yes \_\_\_ No \_\_\_  
Female – pain with periods Yes \_\_\_ No \_\_\_  
    Irregular periods Yes \_\_\_ No \_\_\_  
Could you be pregnant now? Yes \_\_\_ No \_\_\_  
Are you breast feeding? Yes \_\_\_ No \_\_\_  
Do you experience pain with intercourse? Yes \_\_\_ No \_\_\_

### MUSCULOSKELETAL

Joint pain Yes \_\_\_ No \_\_\_  
Joint stiffness or swelling Yes \_\_\_ No \_\_\_  
Weakness of muscles or joints Yes \_\_\_ No \_\_\_  
Muscle pain or cramps Yes \_\_\_ No \_\_\_  
Back pain Yes \_\_\_ No \_\_\_  
Difficulty in walking Yes \_\_\_ No \_\_\_

### INTEGUMENTARY (skin,breast)

Rash or itching Yes \_\_\_ No \_\_\_  
Change in skin color Yes \_\_\_ No \_\_\_  
Change in hair or nails Yes \_\_\_ No \_\_\_  
Change in temperature of extremities Yes \_\_\_ No \_\_\_  
Varicose veins Yes \_\_\_ No \_\_\_  
Breast pain Yes \_\_\_ No \_\_\_

### NEUROLOGICAL

Frequent or recurring headaches Yes \_\_\_ No \_\_\_  
Light headed or dizzy Yes \_\_\_ No \_\_\_  
Convulsions or seizures Yes \_\_\_ No \_\_\_  
Numbness or tingling sensations Yes \_\_\_ No \_\_\_  
Tremors Yes \_\_\_ No \_\_\_  
Paralysis Yes \_\_\_ No \_\_\_  
Stroke Yes \_\_\_ No \_\_\_  
Head injury Yes \_\_\_ No \_\_\_

### PSYCHIATRIC

Memory loss or confusion Yes \_\_\_ No \_\_\_  
Anxiety Yes \_\_\_ No \_\_\_  
Depression Yes \_\_\_ No \_\_\_  
Insomnia Yes \_\_\_ No \_\_\_

### ENDOCRINE

Glandular or hormone problem Yes \_\_\_ No \_\_\_  
Thyroid disease Yes \_\_\_ No \_\_\_  
Diabetes (insulin or Non insulin – circle one) Yes \_\_\_ No \_\_\_  
Excessive thirst or urination Yes \_\_\_ No \_\_\_  
Heat or cold intolerance Yes \_\_\_ No \_\_\_  
Skin becoming dryer Yes \_\_\_ No \_\_\_  
Change in hat or glove size Yes \_\_\_ No \_\_\_

### HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts Yes \_\_\_ No \_\_\_  
Bleeding or bruising tendency Yes \_\_\_ No \_\_\_  
Anemia Yes \_\_\_ No \_\_\_  
Phlebitis Yes \_\_\_ No \_\_\_  
Past transfusion Yes \_\_\_ No \_\_\_  
Enlarged glands Yes \_\_\_ No \_\_\_

### ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:  
Penicillin or other antibiotics Yes \_\_\_ No \_\_\_  
Morphine, Demerol or other narcotics Yes \_\_\_ No \_\_\_  
Novocain or other anesthetics Yes \_\_\_ No \_\_\_  
Aspirin or other pain remedies Yes \_\_\_ No \_\_\_  
Tetanus antitoxin or other serums Yes \_\_\_ No \_\_\_  
Iodine or other antiseptic Yes \_\_\_ No \_\_\_