NY SPINE & REHAB MEDICINE

56 West 45th Street
11th Floor
New York, NY 10036
Phone: (212) 488 9600 Fax: (212) 488 9605

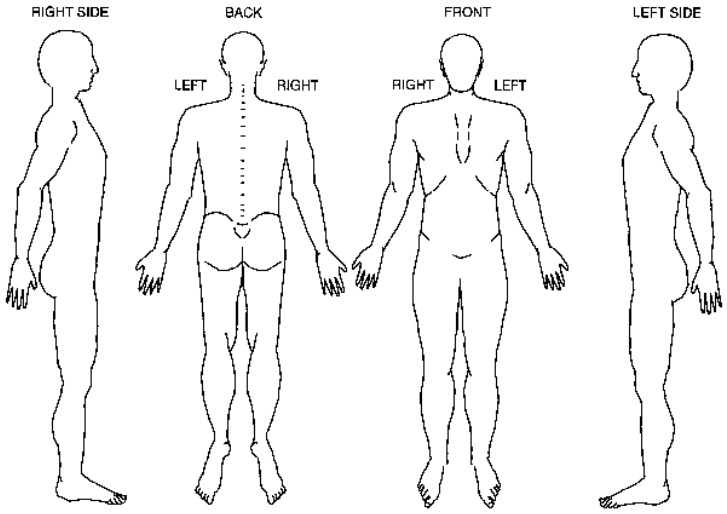
Comprehensive Pain Questionnaire

Name: _____ DOB: ____/____/____ Date: ____/____/____
Height: _____ Weight: _____

PAIN COMPLAINT: _____

WHEN/WHERE/HOW DID THE PROBLEM START:_____
_____
_____

- Where **exactly** is your pain located?



(0-10 scale where 0 is NO PAIN and 10 is the WORST PAIN possible)

I would rate my pain today a _____/10

I would rate my **worst** pain a _____/10

- Describe your pain (check all that apply):

☐ Aching
☐ Burning
☐ Dull
☐ Pins and needles
☐ Shooting
☐ Sharp/stabbing
☐ Soreness
☐ Tingling
☐ Throbbing
Other: _____

- Have your symptoms been:

☐ Worsening
☐ Unchanged
☐ Improving

Is the pain present **(check one):**

☐ Constantly (75-100% of the time)
☐ Frequently (50-75% of the time)
☐ Occasionally (25-50% of the time)
☐ Intermittently (less than 25% of the time)

- What makes your pain **WORSEN**?

☐ Morning hours
☐ Evening hours
☐ Cold weather
☐ Laying flat
☐ Standing
☐ Stairs
☐ Walking
☐ Weather changes
☐ Exercise
☐ Sitting

Other _____

Name: _____ DOB: ____/_____/_____ Today's Date: ____/_____/_____

- How long can you **sit** before you have pain? _____ min _____hrs
- How long can you **stand** before you have pain? _____ min _____hrs
- How long can you **walk** before you have pain? _____ min _____hrs

- How far can you walk without discomfort? _____ blocks

- What makes your pain **IMPROVE**?

☐ Rest
☐ Ice Pack
☐ Hot Pack
☐ Exercise
☐ Walking
☐ Other: _____
☐ Prescription medication
☐ Over the counter medication/Creams/Patches
☐ Sitting
☐ Standing
☐ Leaning over a shopping cart/desk

- Have you seen a physician for this condition? ☐Yes ☐No
- If so, what type of physicians have you seen for your current condition?

☐Primary Care Physician
☐Neurologist
☐Orthopedic surgeon
☐Pain Management
☐Neurosurgeon
☐Physiatrist
☐Rheumatologist
☐Other _____

- What diagnostic studies have you had related to this condition?
  - MRI: Body Part _____ Date: _____
  - CT scan: Body Part _____ Date: _____
  - X-Rays: Body Part _____ Date: _____
  - EMG/Nerve Test: Body Part _____ Date: _____
  - Other: _____ Date: _____

- What treatments have you had in the past for this condition?

Treatments	When was your last session?	Did it provide significant improvement?
☐ Physical Therapy	_____	☐Yes ☐No
☐ Injections	_____	☐Yes ☐No
☐ Chiropractic care	_____	☐Yes ☐No
☐ Acupuncture	_____	☐Yes ☐No
☐ Massage Therapy	_____	☐Yes ☐No

- Have you missed any work in the past 4 weeks due to the pain? ☐Yes ☐No If yes, how many days? _____

- Does the pain or symptoms cause a loss of bowel or bladder control? ☐Yes ☐No

- Is the quality of your sleep affected due to pain? ☐Yes ☐No

PAST MEDICAL HISTORY:

Have you had any of the following health problems? (Please check all that apply)

☐ High Blood Pressure
☐ Angina or chest pain
☐ Asthma or wheezing
☐ (TIA) or stroke
☐ HIV/AIDS
☐ Anxiety
☐ Other; please specify: _____
☐ Diabetes or high blood sugar
☐ Heart attack
☐ Chronic cough
☐ Seizure or epilepsy
☐ Hepatitis B/C
☐ Cancer; please specify what type: _____
☐ Kidney disease
☐ High Cholesterol
☐ Arthritis
☐ Bleeding problems
☐ Depression

Do you have any heart valve disease that requires antibiotic therapy before a procedure? ☐No ☐Yes
Are you on any blood thinners such as Coumadin, Plavix or Aspirin? ☐No ☐Yes; Type: _____

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PSYCHOLOGICAL HISTORY:
Have you been treated for any psychological condition in the past? ☐No ☐Yes; Please specify:
_____
Have you been treated for substance abuse such as alcohol or narcotics in the past? ☐No ☐Yes; Please specify:
_____
Do you currently have any suicidal ideation? ☐No ☐Yes

PAST SURGICAL HISTORY: _____
_____

FAMILY MEDICAL HISTORY: _____
_____

SOCIAL HISTORY:
Alcohol use: How many drinks do you consume on average per day? _____ drinks
Tobacco use: Do you smoke? ☐No ☐Yes; _____ cigarettes/day _____ cigars/day
Recreational drug use: ☐No ☐Yes; ☐ Cocaine ☐ Heroin ☐ Marijuana Other: _____
Marital status: ☐Single ☐Married ☐Separated ☐Divorced Other: _____
Employer: _____ **Occupation:** _____

Do your current job duties involve the following:
- ☐ Prolonged Sitting greater than 30 minutes at a time
- ☐ Prolonged Standing longer than 30 minutes at a time
- ☐ Moderate to heavy lifting greater than 15 lbs consistently

Are you currently on Short or Long Term Disability for this condition: ☐No ☐Yes
Is your injury related to an active Workers Compensation or Motor Vehicle Accident Case? ☐No ☐Yes
Is there any pending litigation related to you injury? ☐No ☐Yes

Review Of Systems – Please mark any new symptoms you have been experiencing in the past 3 months.

Constitutional	**Y**	**N**	**Eyes**	**Y**	**N**	**ENT**	**Y**	**N**	**Endocrine**	**Y**	**N**
Fevers/Chills	☐	☐	Blurry Vision	☐	☐	Sound Sensitivity	☐	☐	Increase in urination	☐	☐
Generalized body aches	☐	☐	Light Sensitivity	☐	☐	Swollen Glands	☐	☐	Unintentional Weight Loss	☐	☐
Fatigue	☐	☐	Loss of Vision	☐	☐	Loss of Hearing	☐	☐	Unintentional Weight Gain	☐	☐

Respiratory	**Y**	**N**	**Cardiac**	**Y**	**N**	**GI**	**Y**	**N**	**GU**	**Y**	**N**
Shortness of breath	☐	☐	Chest Pain	☐	☐	Diarrhea	☐	☐	Burning with urination	☐	☐
Chronic Cough	☐	☐	Irregular Heart Rhythm	☐	☐	Constipation	☐	☐	Pain with urination	☐	☐
Bloody Cough	☐	☐	swelling in legs	☐	☐	Abdominal Pain	☐	☐	Blood in Urine	☐	☐

Neurologic	**Y**	**N**	**MSK**	**Y**	**N**	**Skin**	**Y**	**N**	**Psych**	**Y**	**N**
Numbness	☐	☐	Joint Swelling	☐	☐	Rashes	☐	☐	Depression	☐	☐
Dizziness	☐	☐	Joint Pain	☐	☐	Sores	☐	☐	Anxiety	☐	☐
Headache	☐	☐	Muscle Ache	☐	☐	Itchy Skin	☐	☐	Memory Problems	☐	☐

Heme/Lymph	**Y**	**N**	**Immune**	**Y**	**N**	**GYN (Females)**	**Y**	**N**
Abnormal Bleeding	☐	☐	Recent infection	☐	☐	Abnormal Menstrual Bleeding	☐	☐
Abnormal Bruising	☐	☐	Fevers	☐	☐	Abnormal Menstrual Pain	☐	☐
Lumps in neck or groin	☐	☐	Chills	☐	☐	Breast Lump or Tenderness	☐	☐

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Name: _____ DOB: ____/_____/_____ Today's Date: ____/_____/_____

Current Medication List

Please list your current medications or supplements that you currently take or have taken in the past 30 days.

☐I do not take any medications or supplements _____ (Please initial)

Medication/Vitamin Herbal Remedy:	Dose (i.e. m.g.)	How Often	Route (By mouth, injection	Time last dose taken

Do you have any allergies to Medications?

Medication	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

☐ I do not have any known allergies to any medication

_____ _____

M.D. Signature Date