Pain & Rehab Medicine
920-288-8377

PATIENT PAIN QUESTIONNAIRE

Instructions to Patient:
This questionnaire is designed to help us evaluate and treat your pain in the most effective and appropriate manner possible. Therefore, it is most important that you take the time to complete this questionnaire and bring it with you for your first appointment. Please answer each question as carefully as possible without spending too much time on any one question. **Remember to bring your completed questionnaire with you to your first appointment at our clinic.** Thank you in advance for your cooperation.

- PLEASE PRINT -

Date: _____

Last Name: _____ First name: _____ M.I.: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Education Level: Years of formal education: _____
☐ High school graduate ☐ College graduate ☐ Advanced degree, what degree: _____

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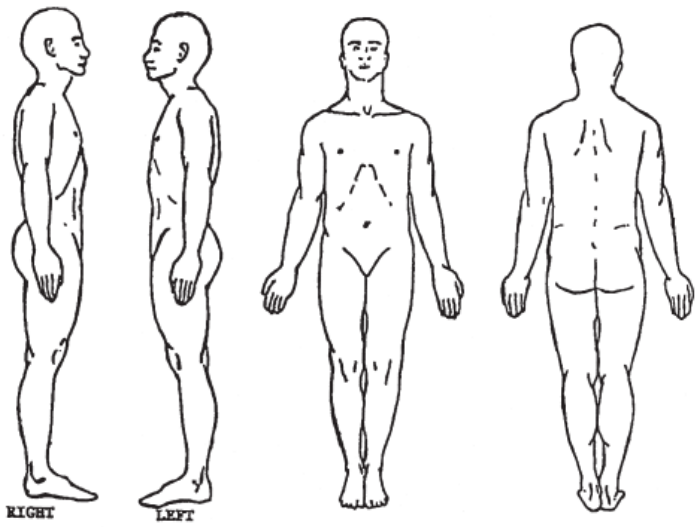
1. Please mark in this diagram where your pain occurs by shading the painful area(s):



2. Please describe the location(s) of your pain:
_____
_____

3. Please rate your pain intensity on a scale from 0 to 10 using the pain scale on page 4:
Number at this time: _____
Number when pain is at its worst: _____
Number when pain is its least: _____
Number the pain is at most times: _____

4. Please check all the words that describe your pain:
☐ Burning ☐ Sharp ☐ Aching ☐ Throbbing
☐ Shooting ☐ Other (describe): _____

5. Does the pain travel anywhere? ☐Yes ☐No
If yes, where? _____

6. How often do you have your pain (check one)?
☐ Constantly (95 to 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)

7. What time of day is your pain worst?
☐ Morning ☐ Afternoon ☐ Evening
☐ Night (sleeping hours) ☐ Pain is always the same
☐ Pain varies, but no particular time

8. Please check all of the sensations that apply to your pain:
☐ Tingling, pins& needles ☐ Numbness
☐ Muscle spasm, tightness ☐ Weakness
☐ Increased sweating ☐ Skin discoloration
☐ Coldness

9. Do you have difficulty controlling your bladder?
☐ Yes ☐ No
If yes, when did this start?_____
Do you have any difficulty controlling your bowels?
☐ Yes ☐ No
If yes, when did this start?_____

10. When did you first notice your pain?
Month_____ Day_____ Year_____

11. Under what circumstances did your pain first begin (check one):
☐ No reason, just began ☐ Accident at home
☐ Accident at work ☐ Work, but not an accident
☐ Following illness ☐ Following surgery
☐ Recreational activity ☐ Motor vehicle accident
☐ Other: _____

Please complete back side

Last Name: _____ First Name: _____ M.I.: _____Date of Birth: _____

12. Describe how your pain started: _____
_____

13. How do the following affect your pain? (Check one for each item)

	Decrease	Increase	No affect
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise (if applicable)	☐	☐	☐
Medication	☐	☐	☐
Relaxation	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Alcoholic drinks	☐	☐	☐

Anything else that makes your pain better? _____
worse? _____

14. When did you first see a doctor for the pain you now have? Month_____ Day____ Year_____

15. About how many doctor visits have you had for your pain in the last year? _____

16. What other types of health care professionals have you seen in connection with your pain? (Psychologist, Physical Therapy, Chiropractor, Massage, etc.) _____

17. Have you ever been hospitalized for your pain?
☐ Yes ☐ No

Hospital	**Dates admitted**
_____	_____
_____	_____

18. Have you had prior episodes of pain that have resolved? ☐ Yes ☐ No
If yes, describe location of pain and when occurred:_____
Describe how long lasted, and how resolved:
_____

19. Have you ever had any of the following?

Test	**Date**	**Where**
☐ X-Rays	_____	_____
☐ MRI	_____	_____
☐ EMG	_____	_____
☐ CT Scan	_____	_____
☐ Myelogram	_____	_____
☐ Bone Scan	_____	_____
☐ None of the above		

20. Have you ever had injections for your pain?
☐ Yes ☐ No
If yes, did they relieve your pain? ☐ Yes ☐ No
If relieved, for how long? ☐ Less than one day
☐ Few days ☐ Few weeks ☐ More than a month

21. Please check all of the treatments you have tried for your pain and complete columns on right:

Treatment	**Dates**	**Results**
☐Exercise	_____	_____
☐Physical therapy	_____	_____
☐Chiropractic	_____	_____
☐Cold	_____	_____
☐Heat	_____	_____
☐Traction	_____	_____
☐Surgery	_____	_____
☐Tens	_____	_____
☐Muscle stimulator	_____	_____
☐Acupuncture	_____	_____
☐Biofeedback	_____	_____
☐Psychotherapy	_____	_____
☐Hypnosis	_____	_____
☐Bed rest	_____	_____
☐Other:_____	_____	_____

22. Are you employed? ☐Full time ☐Part time
☐ Not working due to pain
☐ Not employed, but not related to pain
If you are not working, date last worked: _____
If employed, what type of work do you do?
_____
Employer: _____

How does your pain affect your work?
☐ Not at all
☐ Difficulty doing the following (describe):
_____
_____
☐ Unable to do the following (describe):
_____
_____

Do you currently have restrictions in place on your job?
☐Yes ☐No
If yes, describe: _____

23. Are you now receiving compensation or disability payments? ☐ Yes ☐ No

If yes, who is providing payments? _____
Are payments satisfactory? ☐ Yes ☐ No
Do you have an application for compensation or disability payments pending? ☐ Yes ☐ No

Last Name: _____ First Name: _____ M.I.: _____Date of Birth: _____

Are you now suing anyone because of your pain, or are you planning to sue? ☐ Yes ☐ No
Have you already sued for compensation?
☐ Yes ☐ No
If yes, what was the outcome? _____

24. Since your pain began has the pain:
☐ Increased ☐ Decreased ☐ Stayed the same

25. Since you pain began has your weight:
☐ Increased ☐ Decreased ☐ Stayed the same

26. During the past month, how much did your pain interfere with the following activities?
(Mark one for each item)
1 = Not at all 2= A little bit 3 = Moderately
4 = Quite a bit 5 = Extremely

	1	2	3	4	5
Bathing	O	O	O	O	O
Eating	O	O	O	O	O
Using the bathroom	O	O	O	O	O
Dressing	O	O	O	O	O
Rising from a chair	O	O	O	O	O
Rising from the bed	O	O	O	O	O

27. Have you or anyone in your family ever had a problem with:

YOU	**FAMILY**
☐ Alcohol	☐ Alcohol
☐ Prescription drugs	☐ Prescription drugs
☐ Street/Illegal Drugs	☐ Street/Illegal Drugs
☐ None	☐ None

28. Were you ever the victim of sexual abuse as a child?
☐ Yes ☐ No

29. Have you ever been diagnosed with any of the following?
☐ Attention Deficit Disorder (ADD) ☐ Bipolar
☐ Schizophrenia ☐ Depression
☐ Obsessive Compulsive Disorder (OCD)

30. Have you ever had any type of cancer?
☐ Yes ☐ No If yes, describe: _____

31. Do you have any sort of infection at this time?
☐ Yes ☐ No
If yes, describe: _____

32. If you are married or in a long term relationship, please use the rating scales provided to describe your relationship: (Circle appropriate number):
Before pain began:

Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

NOW:

Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

33. Do you take medicines for pain relief?
☐ No ☐ Occasionally ☐ Daily

34. If you take medicine for pain do you take it:
☐ When needed ☐ Regularly, by the clock

35. On average, does the medicine you take:
☐ Always take the pain away
☐ Usually take the pain away
☐ Always make the pain less
☐ Usually make the pain less
☐ Provide little, if any relief
☐ Do not take pain medicine

36. How long does the medicine provide relief?
☐ Less than one hour ☐ 4 to 6 hours
☐ 1 to 2 hours ☐ More than 6 hours
☐ 2 to 4 hours ☐ Do not take pain medicines

37. Do any of these statements describe your feelings about your pain?
☐ The pain has not caused a change in my mood.
☐ I am having difficulty coping with this pain.
☐ I have difficulty concentrating / thinking because of my pain.
☐ I am anxious because of my pain.
☐ I am angry that I am having this pain.
☐ The pain has led me to feel depressed.

Patient Signature: _____ Date: _____

Last Name: _____ First Name: _____ M.I.: _____Date of Birth: _____

MANKOSKI PAIN SCALE

0 - Pain Free

1 - Very minor annoyance - occasional minor twinges. No medication needed.

2 - Minor Annoyance - occasional strong twinges. No medication needed.

3 - Annoying enough to be distracting. Mild painkillers take care of it. (Aspirin, Tylenol)

4 - Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.

5 - Can't be ignored for more than 30 minutes. Mild painkillers decrease pain for 3-4 hours.

6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (codeine, narcotics) reduce pain for 3-4 hours.

7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.

8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.

9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.

10 - Unconscious. Pain makes you pass out.

Pain rating: 0----------1---------2----------3----------4----------5----------6----------7----------8----------9----------10

No pain Tolerable Not Tolerable worst possible pain