BayCare Clinic

Pain & Rehab Medicine
920-288-8377

PATIENT PAIN QUESTIONNAIRE

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 - **MRN:**____________________ (Office use only)

Date: ___________

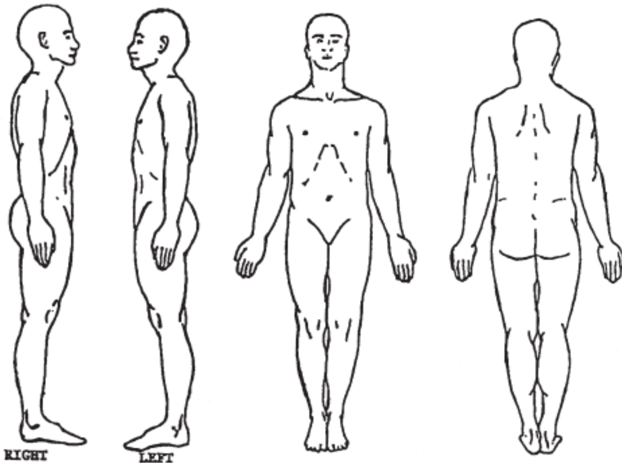
Last Name: ______________________ First name: ________________ M.I.: _______

Date of Birth: ___________ Age: _______ ☐ Male ☐ Female

1. How long ago did your pain start?
Days_______ Months______ Years_______
Specific Date (if known)___________

2. 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: ____________________________________

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



4. Please rate your pain intensity on a scale from 0 = no pain to 10 = incoherent, passing out, worst pain possible:
Number at this time: ________
Number when pain is at its worst: _______
Number when pain is its least: _______
Number the pain is at most times: _______

5. What activities relieve your pain?__________
____
What activities increase your pain? __________
____

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

7. 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?_____________________

8. Have you had any of the following for your pain?

Test	Date	Where
☐ X-Rays	_______	____________
☐ MRI	_______	____________
☐ EMG	_______	____________
☐ CT Scan	_______	____________
☐ Myelogram	_______	____________
☐ Bone Scan	_______	____________

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

Treatment	Dates	Results
☐ Exercise	_______	____________
☐ Physical Therapy	_______	____________
☐ Chiropractic	_______	____________
☐ Heat	_______	____________
☐ Cold	_______	____________
☐ Traction	_______	____________
☐ Surgery	_______	____________
☐ Tens	_______	____________
☐ Muscle stimulator	_______	____________
☐ Acupuncture	_______	____________
☐ Biofeedback	_______	____________
☐ Psychotherapy	_______	____________
☐ Hypnosis	_______	____________
☐ Bed rest	_______	____________
☐ Other: ________	_______	____________

Please complete back side

Last Name: ______________________ First Name: ________________ M.I.: _______Date of Birth: ___________

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

11. 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
If you have had injections for your pain who did them?
___________________When: __________

12. Do you take pain medication? ☐ Yes ☐ No
If yes, what kind? ______________________________
If you take pain medication, 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

13. Have you ever had any type of cancer?
☐ Yes ☐ No
If yes, type: _______________________________

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

15. Is your pain a result of a work-related injury?
☐ Yes ☐ No

16. Are you employed? ☐ Full time ☐ Part time
☐ Retired
☐ 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?
____

17. If you are working, do you currently have restrictions in place on your job? ☐ Yes ☐ No
If yes, describe: ___________________________

18. If you are working, how does your pain affect your work? ☐ Not at all
Difficulty doing the following (describe):
____
____
Unable to do the following (describe):
____
____

19. Do any of these statements describe your feelings about your pain? (Check all that apply)
☐ 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 angry that I am having this pain.
☐ The pain has led me to feel depressed.

20. Is anxiety generally a problem for you?
☐ Yes ☐ No
Is anxiety a significant portion of your discomfort now?
☐ Yes ☐ No

21. How does your pain affect your daily routine?
☐ Not at all
Difficulty doing the following (describe):
____
____
Unable to do the following (describe):
____
____

22. 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

Patient Signature: __________________________ Date: ____________________