Bellevue Spine Specialist

PAIN QUESTIONNAIRE

HISTORY OF PRESENT CONDITION:

When did this episode of pain begin? _____/_____/_____

Due to:	**Description**
⊷ Motor vehicle accident	_____
⊷ On-the-job injury	_____
⊷ Lifting injury	_____
⊷ Falling injury	_____
⊷ Others	_____

Please check the box that best describes your pain:

⊷ Predominant Neck Pain ⊷ Predominant Arm Pain
⊷ Predominant Back Pain ⊷ Predominant Leg Pain

Please describe your pain: (check all that apply)

⊷ Constant ⊷ Intermittent ⊷ Shooting ⊷ Sharp ⊷ Aching
⊷ Burning ⊷ Electrical ⊷ Stabbing ⊷ Dull ⊷ Throbbing

What makes your pain worse? (check all that apply)

⊷ Sitting ⊷ Standing ⊷ Reaching ⊷ Looking up ⊷ Exercise ⊷ Bending forward
⊷ Lifting ⊷ Twisting ⊷ Walking ⊷ Looking down Driving ⊷ Bending backward

What makes your pain better? (check all that apply)

⊷ Sitting ⊷ Standing ⊷ Stretching ⊷ Changing positions
⊷ Ice\Heat ⊷ Pain pills ⊷ Exercising ⊷ Lying down

Do you have any numbness? ⊷ yes ⊷ no
If yes, where? _____

Do you have any weakness? ⊷ yes ⊷ no
If yes, where? _____

Date:_____ Name:_____ Date of Birth:_____

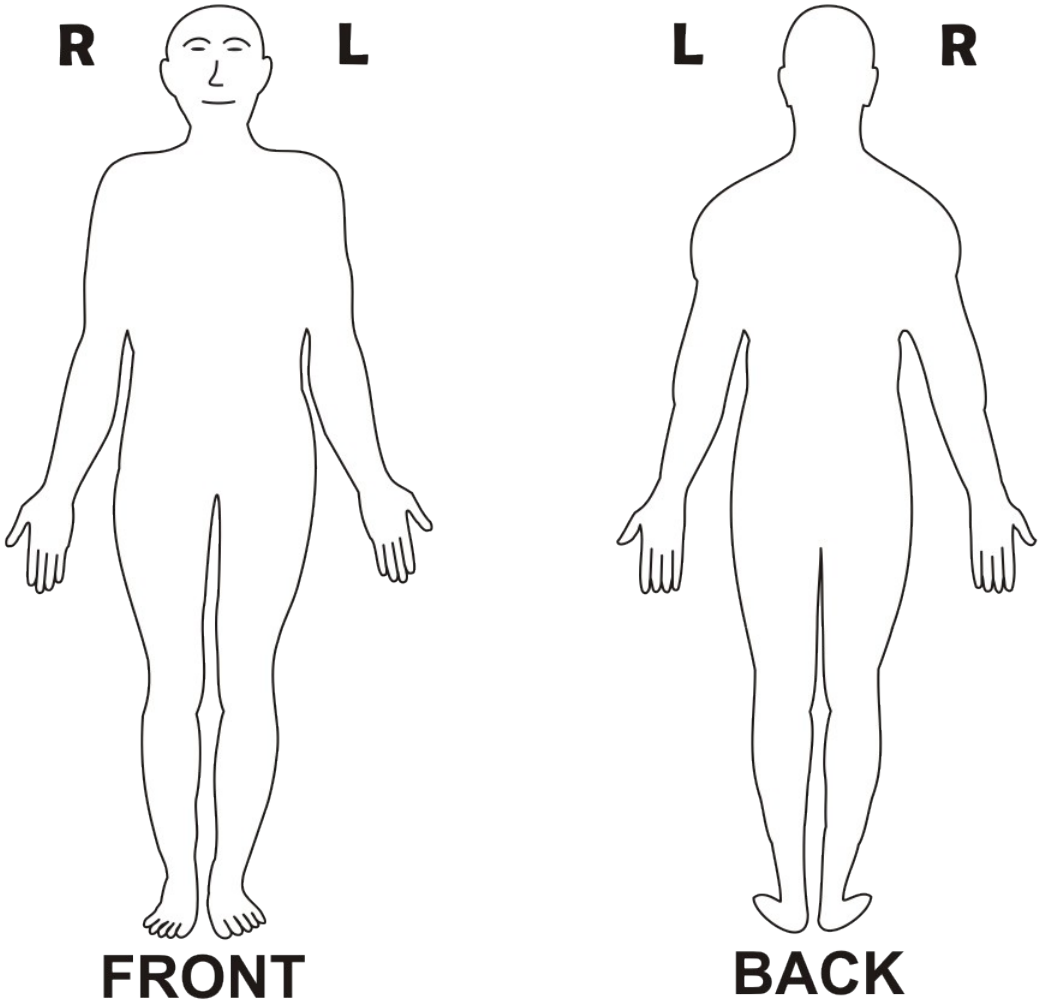
What treatments have you had for your pain?

Injection: _____
Medication: _____
Physical Therapy: _____
Chiropractic Care: _____
Acupuncture: _____
Neck/Back Surgery: _____

Please rate your current pain on a 0 – 10 scale: **0 = No Pain** **10 = Worst Pain**

0 1 2 3 4 5 6 7 8 9 10
|--------|--------|-------|-------|-------|-------|-------|-------|-------|-------|

Please shade in the areas where your pain is located:



Date:_____ Name:_____ Date of Birth:_____

General Health History

Please list any medical problems you have:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list all surgeries you have had and approximate date of each one:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

	NAME OF MEDICATION	DOSE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

	MEDICATION ALLERGIES	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Social History

Employment status: _____

Tobacco Product Use: Per day _____

Alcohol Consumption: Daily _____ Weekly _____ Social _____

(Office use only) MD Initial:_____