



44 Route 23 North, Suite 15B
Riverdale, NJ 07457

Phone: (973) 400-1716 Fax: (973) 400-1631

Comprehensive Pain Questionnaire

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Age _____

Weight _____ Height _____

Chief Complaint

What is the main problem for which you are seeking treatment at New Jersey Pain Care Center?

ONSET OF PAIN

How did your current pain start?

- Injury at work
- Treatment caused (e.g., radiation, surgery, etc.)
- Injury, not at work
- Motor vehicle accident
- Illness, non-injury
- Undetermined
- Other _____

DURATION

How long have you had your current pain problem? _____ Years _____ Months

PRIOR CONSULTATIONS

Which physicians have you seen for your current condition?

- | | |
|---|---|
| <input type="checkbox"/> Primary Care Physician _____ | <input type="checkbox"/> Neurosurgeon _____ |
| <input type="checkbox"/> Neurologist _____ | <input type="checkbox"/> Physiatrist _____ |
| <input type="checkbox"/> Orthopedic surgeon _____ | <input type="checkbox"/> Other _____ |

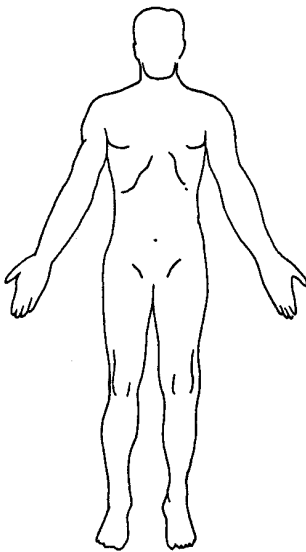
DIAGNOSTIC STUDIES

What diagnostic studies have you had?

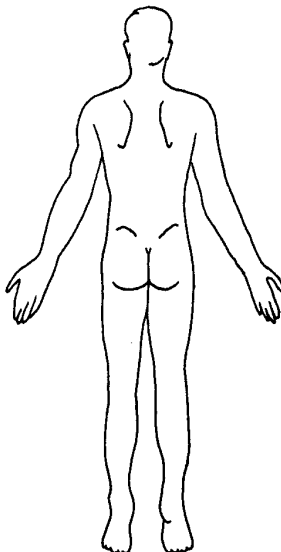
- | | |
|--------------------------------------|-------------|
| <input type="checkbox"/> MRI: | |
| a. Back | Date: _____ |
| b. Neck | Date: _____ |
| <input type="checkbox"/> CT scan: | |
| a. Back | Date: _____ |
| b. Neck | Date: _____ |
| <input type="checkbox"/> EMG | Date: _____ |
| <input type="checkbox"/> X-rays | Date: _____ |
| <input type="checkbox"/> Other _____ | Date: _____ |

PAIN LOCATION

Please describe the location(s) of your pain:



Front



Back

Please mark the location(s) of your pain on the diagrams above. If whole areas are painful, please shade in the painful area.

RATE YOUR PAIN

(0-10 scale where 0 is no pain and a 10 is the worst possible pain)

I would rate my pain today a _____/10

I would rate my worst pain a _____/10.

I would rate my pain when under control as a _____/10.

I could accept or live with a level of pain at a _____/10.

PAIN QUALITY

How would you describe the pain?

- | | | | |
|---|-----------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp | <input type="checkbox"/> Cutting | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Numbness | <input type="checkbox"/> Dull | |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Pressure | <input type="checkbox"/> Soreness | |
| <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Shooting | <input type="checkbox"/> Other _____ | |

In general, during the past month when has your pain been (please check one)?

- Worsening Improving Unchanged

TIMING OF PAIN

How often do you have your pain? (Please check one)

- Constantly (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)

ACTIVITIES AND YOUR PAIN

During the past month, check the activities that you avoided because of pain:

- | | |
|--|--|
| <input type="checkbox"/> Going to work | <input type="checkbox"/> Performing household chores |
| <input type="checkbox"/> Doing yard work or shopping | <input type="checkbox"/> Socializing with friends |
| <input type="checkbox"/> Participating in recreation | <input type="checkbox"/> Having sexual relations |
| <input type="checkbox"/> Physically exercising | |

Does your pain cause any of the following?

- Loss of bowel control Loss of bladder control Loss of sleep

How many blocks can you walk before having to stop secondarily to pain?

- Less than a block _____ blocks

How many minutes or hours can you sit before having to get up and move about?

_____ Hours _____ Minutes

How many minutes or hours can you stand before you have to sit down?

_____ Hours _____ Minutes

How often during the day do you lie down because of pain?

- Never Seldom Sometimes Often Constantly

RELIEVING AND AGGREGATING FACTORS

How do the following affect your pain? (Please check one for each item)

	Decrease	No Change	Increase
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking about something else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
<input type="checkbox"/> Hospital bed rest		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Traction		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypnosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nerve block or injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TENS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical therapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercise		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Biofeedback		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR MEDICAL HISTORY

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

- High blood pressure Diabetes or high blood sugar Kidney disease
 - Angina or chest pain Heart attack Liver disease
 - Asthma or wheezing Chronic cough Arthritis
 - (TIA) or stroke Seizure or epilepsy Bleeding problem
 - Cancer; please specify what type _____
 - Other; please specify _____
-
-

PAST SURGICAL HISTORY

<i>Date (approximate)</i>	<i>Hospital</i>	<i>Type of Operation</i>

FAMILY HISTORY

Mother

Father

Siblings

Other

REVIEW OF SYSTEMS

Constitutional

- Weight change
- Loss of appetite
- Fatigue
- Insomnia
- Fever

Cardiovascular

- Heart trouble
- Chest pain
- Heart murmur
- Palpitations
- Varicose veins
- Swelling of the feet or ankles

Gastrointestinal

- Nausea
- Diarrhea
- Constipation
- Abdominal pain
- Blood in the stool

Neurological

- Frequent headaches
- Light headed or dizzy
- Convulsions or seizures
- Numbness or tingling
- Tremors
- Paralysis
- Head injury
- Memory loss
- Fainting
- Poor balance

Eyes

- Eye disease
- Glasses or contacts
- Blurred or double vision
- Vision loss

Genitourinary

- Frequent urination
- Urgency of urination
- Painful urination
- Incontinence
- Sexual difficulty
- Kidney stones

Respiratory

- Shortness of breath
- Chronic cough
- Wheezing

Ears/Nose/Mouth/Throat

- Hearing loss
- Ringing in the ears
- Sinus problems
- Nose bleeds
- Mouth sores
- Swollen glands in the neck

Hematological

- Bleeding tendency
- Anemia
- Recurrent infections

Psychiatric

- Nervousness
- Depression
- Hallucination

Musculoskeletal

- Joint pain
- Joint swelling
- Weakness of muscles or joints
- Muscle pain or cramps
- Back pain
- Difficulty walking

Endocrine

- Excessive thirst
- Heat or cold intolerance
- Glandular or hormone problems

Skin

- Rash or itching
 - Change in skin color
 - Change in hair or nails
-

MEDICATIONS

Indicate the prescription medications you currently taking by checking the box. Please tell us the dosage (if known) and number of pills you take (on average) of this medication. Write this in the space next to the name of the medication.

If you can remember, draw a line through the name of any medications that you have tried in the past but are no longer taking.

- | | |
|---|--|
| <input type="checkbox"/> Actiq | <input type="checkbox"/> Mobic |
| <input type="checkbox"/> Adapin (Doxepin) | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Amrix | <input type="checkbox"/> MS Contin |
| <input type="checkbox"/> Anaprox (Naproxen) | <input type="checkbox"/> Naprelan |
| <input type="checkbox"/> Anexsia (Hydrocodone) | <input type="checkbox"/> Naprosyn |
| <input type="checkbox"/> Ativan | <input type="checkbox"/> Norco (Hydrocodone) |
| <input type="checkbox"/> Avinza | <input type="checkbox"/> Norflex |
| <input type="checkbox"/> Axert | <input type="checkbox"/> Norpramin (Desipramine) |
| <input type="checkbox"/> Baclofen (Lioresal) | <input type="checkbox"/> Opana (IR/ER) |
| <input type="checkbox"/> Buprenorphine | <input type="checkbox"/> Oxycodone |
| <input type="checkbox"/> BuSpar | <input type="checkbox"/> Oxycontin |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Pamelor (Nortriptyline) |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Percocet (Oxycodone) |
| <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Percodan (Oxycodone) |
| <input type="checkbox"/> Darvocet | <input type="checkbox"/> Provigil |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Prozac |
| <input type="checkbox"/> Desyrel (Trazodone) | <input type="checkbox"/> Restoril |
| <input type="checkbox"/> Dilaudid | <input type="checkbox"/> Ritalin |
| <input type="checkbox"/> Elavil (Amitriptyline) | <input type="checkbox"/> Robaxin |
| <input type="checkbox"/> Empirin with codeine | <input type="checkbox"/> Roxicodone |
| <input type="checkbox"/> Endocet | <input type="checkbox"/> Sinequan (Doxepin) |
| <input type="checkbox"/> Feldene | <input type="checkbox"/> Skelaxin |
| <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Soma |
| <input type="checkbox"/> Fiorinal | <input type="checkbox"/> Tegretol |
| <input type="checkbox"/> Fiorinal with codeine | <input type="checkbox"/> Tofranil (Imipramine) |
| <input type="checkbox"/> Flexeril | <input type="checkbox"/> Topamax |
| <input type="checkbox"/> Frova | <input type="checkbox"/> Toradol |
| <input type="checkbox"/> Halcion | <input type="checkbox"/> Tylenol with codeine |
| <input type="checkbox"/> Ibuprofen (Motrin) (Advil) | <input type="checkbox"/> Tylox |
| <input type="checkbox"/> Imitrex (Sumatriptan) | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Indocin | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Kadian | <input type="checkbox"/> Ultracet |
| <input type="checkbox"/> Klonopin (Clonazepam) | <input type="checkbox"/> Ultram (Tramadol) |
| <input type="checkbox"/> Lexapro | <input type="checkbox"/> Ultram ER |
| <input type="checkbox"/> Lidoderm 5% | <input type="checkbox"/> Xanax (Alprazolam) |
| <input type="checkbox"/> Limbrel | <input type="checkbox"/> Zanaflex (Tizanidine) |
| <input type="checkbox"/> Lioresal | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Lortab | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Lyrica | <input type="checkbox"/> _____ |
| <input type="checkbox"/> (Hydrocodone) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> _____ |

ALLERGIES

I am allergic to dye (Contrast)

Please indicate the names of any medications that you are allergic to in the space below

EDUCATION

Your highest educational level achieved:

- Graduate or professional training (obtained degree)
- College graduate (obtained degree)
- Partial college training
- High school graduate
- GED or trade-technical school graduate
- Partial high school (10th grade through partial 12th)
- Partial junior high school (7th grade through 9th grade)
- Elementary school (6th grade or less)

EMPLOYMENT

Your current or former occupation:

- Skilled trade or clerical (e.g., carpenter, electrician, truck driver, secretary)
- Semi-skilled or unskilled (e.g., dishwasher, porter, assembler)
- Business executive or managerial
- Professional (e.g., lawyer, teacher, nurse, physician, psychologist)
- Homemaker
- Other

Current employment status (please check all that apply):

- Employed full-time
- Employed part-time
- Unemployed
- Homemaker
- Retired
- Student
- Unemployed because of pain
- Part-time because of pain

If you are currently unemployed, indicate how long you have been off work: (If employed, do not answer)

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> 1 - 3 weeks | <input type="checkbox"/> 8 - 11 months | <input type="checkbox"/> 25 or more months |
| <input type="checkbox"/> 1 - 3 months | <input type="checkbox"/> 12 - 18 months | |
| <input type="checkbox"/> 4 - 7 months | <input type="checkbox"/> 19 - 24 months | |

