PAIN SPECIALISTS of ORANGE COUNTY
949-297-3838

Location: ⬭ Irvine ⬭ Laguna Hills ⬭ Mission Viejo ⬭ San Clemente ⬭ Fountain Valley

PAIN QUESTIONNAIRE

Date Survey Completed: ___________________________ Patient Date of Birth: _____________

Patient Name: ___________________________ ___________________________ _______
First Last MI

Address:
____
Street City State Zip

Primary Phone: _________________________ Alternate Phone: ___________________________

May we leave a message at the above listed phone number(s)? _____________________________

Email Address: ____

May we contact you via email at the address listed above? _________________________________

Referring Physician Name: ____

Referring Physician Address: ____

Referring Physician Phone: ____

(For Office Use Only)

Questionnaire Reviewed By: __________________________________ ____________________
Physician Name Date

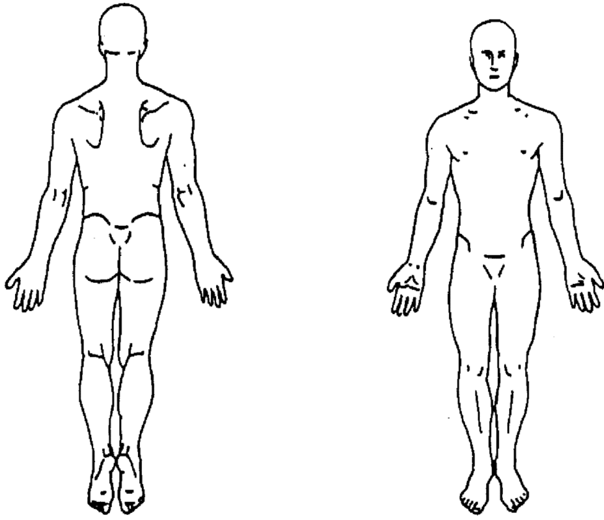
____

____

____

____

Please indicate on the chart the location of your pain:



Please check the words that best describe your pain:

☐ Aching ☐ Sharp
☐ Burning ☐ Hot
☐ Dull ☐ Cold
☐ Throbbing ☐ Numb
☐ Nagging ☐ Tingling
☐ Stabbing ☐ Shooting

Is your pain constant or intermittent?
☐ Constant ☐ Intermittent

How long have you had this pain?
____

Intensity of pain (Circle a Number):

☺ 0______1_______2_______3_______4_______5_______6_______7_______8________9_______10 ☹
No Pain Severe Pain

What brings on your pain or makes it worse? (Example: coughing, sneezing, walking, bending, sitting)

What makes the pain better? (Example: lying down, sitting, standing)

Does the pain limit your activities? □Yes □ No
If so, please explain:

Does the pain affect your sleep? □Yes □No
If so, Please describe your sleeping habits:

Is your pain the result of an illness or injury? □Yes □ No Job related? □Yes □ No
If so please explain (including the date of the illness or injury):

Are you currently working? □Yes □ No What is your usual occupation?
If not, when did you last work?

Does your pain interfere with your occupation or employment? □Yes □ No
If so, Please explain:

Are you receiving disability payments because of your pain? □Yes □ No
If so, please explain:

Are any disability claims or lawsuits pending (related to your pain)?
If so, please explain:

Diagnostics Tests:
Please check any diagnostic tests you have had for this condition:
☐ MRI ☐ CT Scan ☐ X-Rays ☐ EMG ☐ Other______________

Please check any of the following treatments you may have had, including the date and results if possible.

Previous Treatments			**Dates**	**Did this Help You?**	
Physical Therapy	**Yes**	**No**	______________________	**Yes**	**No**
Nerve Blocks/Epidurals	**Yes**	**No**	______________________	**Yes**	**No**
Traction	**Yes**	**No**	______________________	**Yes**	**No**
Acupuncture	**Yes**	**No**	______________________	**Yes**	**No**
Chiropractic	**Yes**	**No**	______________________	**Yes**	**No**

Others (Please include all medications which were tried in the past)

____

Past Surgical History:

Surgery		Surgery	
________________________	Date________	________________________	Date________
________________________	Date________	________________________	Date________

Past Medical History:

Do you have a history of any of the following?

Chest Pain	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Ulcer Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Abnormal Heart Rhythm	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Bleeding Disorders	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Kidney Failure	☐ Yes	☐ No	Psychiatric Disorders	☐ Yes	☐ No
Prostate Trouble	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Liver Failure	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Are You Pregnant?	☐ Yes	☐ No

Please list any other medical problems not listed above:____

Review of Systems:

Please review the list below and indicate if you have currently, or have ever had a problem in any of these areas:

Fatigue	☐ Yes	☐ No	Joint pain/swelling	☐ Yes	☐ No
Poor sleep	☐ Yes	☐ No	Heat intolerance	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Cold intolerance	☐ Yes	☐ No
Swelling in legs	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Chronic cough/wheezing	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bowel incontinence	☐ Yes	☐ No	Loss of balance	☐ Yes	☐ No
Urinary incontinence	☐ Yes	☐ No	Weakness	☐ Yes	☐ No

Social History:

How often do you use tobacco?	☐ Never	☐ Occasionally	☐ Regularly, packs per day___________
How often do you use alcohol?	☐ Never	☐ Occasionally	☐ Regularly, cups per day ___________
How often do you use recreational drugs?	☐ Never	☐ Occasionally	☐ Regularly

Family History: Please list any diseases that run in your family (e.g.: diabetes, heart disease, cancer, etc.):

____

Please list all medications you are currently taking:

Medication	Dose	Medication	Dose
________________________	_______	________________________	_______
________________________	_______	________________________	_______
________________________	_______	________________________	_______
________________________	_______	________________________	_______

Allergies: ____

Please add any comments you feel would be helpful in treating your condition:

____

Your Signature:_______________________________________

Updated: 02/0; /12