Benjamin Lee, MD Pain Questionnaire

Please completely fill out the following information. All questions are pertinent in order to provide you with comprehensive care.

GENERAL INFORMATION

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

_____ Sex: _____ Age: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Email: _____

Primary Care Physician: _____ PCP Phone: (____) _____

Referring Physician: _____ Ref Phone: (____) _____

Emergency Contact: _____ E.C. Phone: (____) _____

E.C. Relationship: _____ Highest Level of Education: _____

Language Spoken: _____ Interpreter Needed: yes no

Please list all who are currently living in your household: _____

_____

Are there any cultural, religious, social or financial concerns that we should know about in order to better meet your needs?: _____

COMPENSATION AND LEGAL INFORMATION

1. Are you receiving compensation or disability payments now? _____
   If yes, are the payments adequate? _____
2. Do you have an application for compensation or disability payments pending? _____
3. Are you suing anyone because of your pain or injury? _____
4. Have you brought suit in the past? _____ Outcome? _____

PAIN INFORMATION

1. What is your main pain problem? _____
2. Has your pain progressively gotten worse? _____
3. What caused your current pain? _____
4. In general, is your pain worse: morning afternoon evening night unknown
5. What do you do to decrease your pain? _____
6. What do you do that increases your pain? _____
7. How often do you have to rest from your pain? _____

8. Has your pain interfered with:

Household chores	Spending time with friends/family	Sexual activity
Yard work	Recreational activities	Physical activity
Shopping	Sleeping	Eating

9. Has your pain affected your relationship with your family/friends? _____

   If so, how? _____

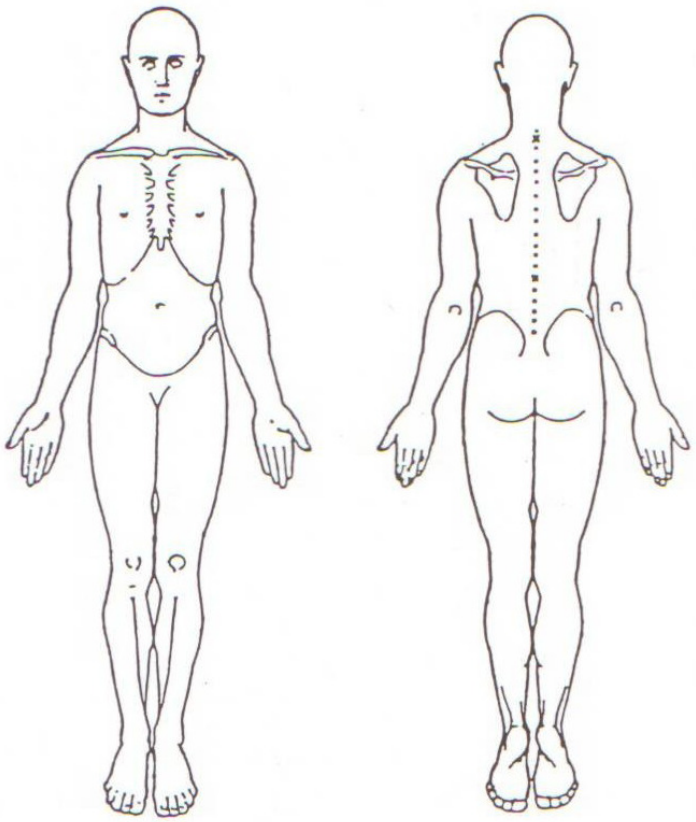
10. What level of treatment are you expecting from the Pain Clinic? _____

11. Please give any additional information that you think we should know: _____

_____

PAIN DIAGRAM

Directions: Shade in the areas where you are currently having pain



Pain #1 – Most Severe Pain

Where is it? _____

When did it start? _____

Was there an accident? _____

On a scale of 1 to 10, with 10 being the worst Pain, when is this pain at its:
Worst: _____

Best: _____

Now: _____

On average: _____

Describe the pain: _____

Is your pain continuous or intermittent?

_____

Pain #2 – Accompanied Pain

Where is it? _____

Where did it start? _____

On a scale of 1 to 10, with 10 being the worst Pain, when is this pain at its:
Worst: _____

Best: _____

Now: _____

On average: _____

Describe the pain: _____

Does your pain stop or is it intermittent (starts

and stops)? _____

SOCIAL HISTORY

1. Do you smoke? _____ How many packs per day? _____ How long? _____

2. Do you drink alcoholic beverages? _____
What type and how often? _____

3. Do you use any recreational drugs? _____
What type and how often? _____

5. What is your current/most recent occupation? _____

6. What is your current employment status? _____

7. Has your employer been helpful and understanding of your pain problem? _____

8. Would you return to work if you had no pain problem? _____

9. Have you tried to return to work? _____

10. Is your previous job still open to you? _____

11. When was your last day of work? Month_____ Day_____ Year_____

FAMILY HISTORY

Please list your family members' medical history. For example: arthritis, osteoporosis, hemophilia, high blood pressure, high cholesterol, acid reflux, cancer, heart disease, etc…)

Father: _____

Mother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Siblings: _____

Is your family supportive of your pain? _____

Your marital status: _____ Children? _____ Age: _____

Are you living in a house, condo, apartment, nursing home, other? _____

COPING INFORMATION

1. Have you ever experienced physical, emotional, sexual abuse? _____

If yes, please explain: _____

2. Have you ever had psychiatric/psychological treatment? _____

3. For your pain, please check all the treatments you have tried and when:

Physical Therapy _____ Nerve Block/Injection _____ Heat Treatment _____

Exercise _____ TENS stimulator _____ Massage Therapy _____

Acupuncture _____ Traction _____ Other _____

4. Of the above treatments, which helped and for how long? _____
5. Have you ever been in treatment for misuse of alcohol/illegal drugs/prescribed meds? _____

If yes, where and when? _____

6. Are there things causing stress in your life other than your current pain problem? _____

If yes, please describe: _____

7. In the past year has your weight increased or decreased? _____ How much? _____
8. If your weight decreased, were you dieting? _____

MEDICAL INFORMATION

1. Do you have any allergies? _____
2. Aside from your pain problem, how is your current health? _____
3. Please check all of the following health problems that have applied to you:

High Blood Pressure ____	Diabetes ____	Angina or chest pain ____
Thyroid Problems ____	Heart Attack ____	Kidney Problems ____
Bowel Problems ____	Liver Disease ____	Blood/Clotting Problems ____
Seizure/Epilepsy ____	Stroke ____	Cancer _____
Bleeding Problems ____	Arthritis ____	Stomach Problems ____
Osteoporosis ____	Asthma/TB ____	Recent Falls ____
Need for Antibiotics prior to surgery ____	Recent change in mobility/self-care ____	

4. What is your functional status: Independent Difficulty w/ Balance History of falls
5. Check the following that you use:

Glasses____	Cane_____	Brace _____	Wheelchair_____
Walker ____	Hearing Aid _____	Crutches _____	Dentures _____
Prosthesis ____	Other _____		

IMAGING

Please list any imaging you have had done in the past 2 years related to your pain:

DATE	TYPE OF IMAGE	WHERE IT WAS DONE

MEDICATIONS LIST

Please list ALL medications you are taking NOW for any reason, prescribed by a doctor or not.

NAME OF DRUG	DOSAGE	TIMES PER DAY TAKEN	REASON FOR TAKING

Please list any medications you have taken in the past for your pain and why you are no longer taking them: _____

SURGERIES

Please list all of the surgeries you have had:

DATE	HOSPITAL	DOCTOR	TYPE OF OPERATION	DID IT HELP

Please list any medical conditions, when you were diagnosed, and the treating physician:

Date Diagnosed	Medical Condition	Treating Physician