

## PAIN QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please describe your major complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

If you can, please describe how the condition started: \_\_\_\_\_  
\_\_\_\_\_

Is this condition related to an automobile accident? \_\_\_\_\_ An injury at work? \_\_\_\_\_

Have you had this or a similar condition in the past? \_\_\_\_\_ If so, when: \_\_\_\_\_

Which of the following aggravates your condition?

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Sitting Down                | <input type="checkbox"/> Sitting for long periods  | <input type="checkbox"/> Walking    |
| <input type="checkbox"/> Standing                    | <input type="checkbox"/> Standing for long periods | <input type="checkbox"/> Lying down |
| <input type="checkbox"/> Body movement               | <input type="checkbox"/> Deep breathing            | <input type="checkbox"/> Sleeping   |
| <input type="checkbox"/> Coughing                    | <input type="checkbox"/> Sneezing                  | <input type="checkbox"/> Straining  |
| <input type="checkbox"/> Specific movement (s) _____ |  |                                     |
| <input type="checkbox"/> Other _____                 |  |                                     |

Which of the following relieves your condition?

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Sitting Down      | <input type="checkbox"/> Walking                | <input type="checkbox"/> Lying down |
| <input type="checkbox"/> Massage           | <input type="checkbox"/> Moist heat/ Hot shower | <input type="checkbox"/> Ice        |
| <input type="checkbox"/> Sleeping          | <input type="checkbox"/> Exercise               | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Medications _____ |   |                                     |
| <input type="checkbox"/> Other _____       |   |                                     |

Is this condition:

- getting worse     getting better     constant     coming & going

Which of the following professionals have you sought treatment for this condition:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Family physician   | <input type="checkbox"/> Neurologist       | <input type="checkbox"/> Neurosurgeon  |
| <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Physiatrist       | <input type="checkbox"/> Chiropractor  |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Other _____        |  |  |

Briefly describe the treatments you have received: \_\_\_\_\_

Please describe which treatment, if any, have provided relief for this condition & how long did it last:  
\_\_\_\_\_  
\_\_\_\_\_

What tests have been performed?  MRI     CAT scan     X-rays     EMG/NCV     Other \_\_\_\_\_

Is there a secondary complaint that you would like to discuss with the doctor? \_\_\_\_\_

This history has been completed to the best of my ability.

Signature (or guardian) \_\_\_\_\_

Date \_\_\_\_\_