



1. Which statement **best** describes your pain?

- Always present, always the same intensity.
- Always present, intensity varies.
- Usually present, but have short periods without pain.
- Often present, but have pain free periods lasting from one to several hours.
- Often present, but I am pain free for most of the day.
- Occasionally present – have pain once to several times per day, lasting few minutes to an hour.
- Occasionally present for brief periods, a few seconds to a few minutes.
- Rarely present – have pain every few days or weeks.

2. Does your pain travel anywhere?

- Yes                       No

3. Do you have arm pain? (Circle One)

Left                      Right

4. Do you have leg pain? (Circle One)

Left                      Right

5. What time of day is your pain worse?

- Morning on arising                       Bedtime
- Later in the morning                       Night (During usual sleeping hours)
- Afternoon                       Pain is always the same
- Evening                       Pain varies, but is not worse at any particular time.

6. Do you have:

- |                          |  |                        |  |
|--------------------------|--|------------------------|--|
| Weakness                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscle Spasms          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Problems Walking         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel/Bladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Use Cane/Walker          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Morning Stiffness      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Numbness                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tingling, Pins & Needles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

7. Do any of the following make your pain feel **worse**?

- |                    |  |                   |  |
|--------------------|--|-------------------|--|
| Coughing, Sneezing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Activity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sitting            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexual Activity   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Standing           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (Describe)  | _____  |
| Lying Down         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   | _____  |
| Walking            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   | _____  |

8. Do any of the following make your pain feel **better**?

- |                  |  |                               |  |
|------------------|--|-------------------------------|--|
| Relaxation       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heat                          | <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Sitting          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medicines                     | <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Standing         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Walking                       | <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Lying Down       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (Describe)              | _____  |
| Alcoholic Drinks | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                         |  |
| Sexual Activity  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nothing makes it feel better: | <input type="checkbox"/> TRUE <input type="checkbox"/> FALSE |

9. Does pain interrupt your sleep?  Yes  No

10. Do you have a job related injury?  Yes  No

If **Yes**, please give the date injured and describe the injury. \_\_\_\_\_

\_\_\_\_\_

11. Briefly describe your job requirements. \_\_\_\_\_

\_\_\_\_\_

12. When did you first see a doctor for the pain you now have? Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_

13. Approximately how many physician visits have you had for your pain in the last year? \_\_\_\_\_

14. Have you been hospitalized for pain?  Yes  No If yes, please list below:

Hospital	Date Admitted
_____	_____
_____	_____
_____	_____

Please use the following scale to rate your ability to cope with your pain: (Circle appropriate number)

Cope Very Well    0   1   2   3   4   5   6   7   8   9   10    Totally Unable to Cope

|\_| |\_| |\_| |\_| |\_| |\_| |\_| |\_| |\_| |\_|

Since your pain began, has it (circle one)    Increased    Decreased    Stayed the Same

15. Are you employed now?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes – Full Time                   | <input type="checkbox"/> On Sick Leave                      |
| <input type="checkbox"/> Yes – Full Time with Restrictions | <input type="checkbox"/> No, but not because of pain        |
| <input type="checkbox"/> Yes – Part Time                   | <input type="checkbox"/> No, unable to work because of pain |
| <input type="checkbox"/> Yes – Part Time with Restrictions | <input type="checkbox"/> Disabled                           |

16. Did you stop working because of pain?  Yes  No

17. Do you feel you can return to work?  Yes  No

18. Any previous work injuries?  Yes  No
19. Have you ever applied for disability?  Yes  No
20. Are you involved in or considering a lawsuit?  Yes  No

If **yes**, name of your attorney. \_\_\_\_\_

21. Have you received financial compensation related to your pain? Yes No
22. Are you now bringing a lawsuit because of your pain? Yes No
23. Are you planning to sue because of your injury? Yes No
24. Have you ever had psychological or psychiatric treatment? Yes No

25. Have you had any of the following conditions? (Circle **ALL** that apply)

- |                             |                              |                       |
|-----------------------------|------------------------------|-----------------------|
| Bronchitis                  | Breast Problems              | Joint Disease         |
| Asthma                      | Headache                     | Gout                  |
| Pneumonia                   | Dizziness/Fainting           | Skin Rash             |
| Shortness of Breath         | High Blood Pressure          | Osteoporosis          |
| Heart Disease               |                              | Sleeping Difficulties |
| Heart Murmur                | Diabetes                     | Neurological Problems |
| Chest Pain                  | Bladder Problems             | Depression            |
| Stroke                      | Incontinence                 | Anxiety               |
| Anemia                      | Discharge from Urethra/Penis | Nervousness           |
| Blood Disorders             | Prostate Problems            | Psychiatric Disorder  |
| HIV/Venereal Disease        | Bowel Problems               | Measles               |
| Thyroid Disease             | Hearing Problems             | Mumps                 |
| Jaundice or Liver Disease   | Vision Problems              | Rubella               |
| Gallbladder Problems        | Circulation Problems         | Tetanus               |
| Hepatitis                   | Blood Clots                  | Diphtheria            |
| Pancreatitis                | Fluid Retention              | Scarlet Fever         |
| Tuberculosis                | Ulcers                       | Rheumatic Fever       |
| Appendicitis                | Stomach Problems             | Polio                 |
| Endometriosis               | Hiatal Hernia                | Cancer - Where        |
| Pelvic Inflammatory Disease | Arthritis                    | Drug Abuse            |
|                             |                              | Alcohol Abuse         |

Other:

26. Do you use tobacco? (Circle One) Yes No  
 Type? \_\_\_\_\_ Amount Per Day \_\_\_\_\_
27. Do you use alcohol? (Circle One) Yes No  
 Type? \_\_\_\_\_ Amount Per Day \_\_\_\_\_
28. Caffeine Use? (Circle One) Yes No
29. Last Menstrual Period. \_\_\_\_\_ Are Menses Regular: Yes No
30. Number of Children? \_\_\_\_\_
31. Marital Status? Single Married Divorced Widowed Other
32. Who lives with you? \_\_\_\_\_

Please list all prior surgeries and the date procedure was done. \_\_\_\_\_

---

---

---

Please list all allergies and their side effects. \_\_\_\_\_

---

---

Please list all medications either prescribed by a physician or over the counter. Please include dosage and frequency. \_\_\_\_\_

---

---

---

Did (or does) anyone in your immediate family (father, mother, brother, sister, aunt, uncle) have cancer, diabetes, tuberculosis, heart disease, spine problems, arthritis, bleeding disorders, or mental illness? (List disease and relationship) \_\_\_\_\_

---

---

---

**Comments:** \_\_\_\_\_

---

---

---

---

---

---

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_