

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
_____	_____
_____	_____
_____	_____

15. Have you had any of the following?

- | | | |
|---|-------------|------------|
| <input type="checkbox"/> X-Rays | Where _____ | When _____ |
| <input type="checkbox"/> Myelogram | Where _____ | When _____ |
| <input type="checkbox"/> EMG | Where _____ | When _____ |
| <input type="checkbox"/> Cat Scan | Where _____ | When _____ |
| <input type="checkbox"/> MRI Scan | Where _____ | When _____ |
| <input type="checkbox"/> Bone Scan | Where _____ | When _____ |
| <input type="checkbox"/> Other (Describe) | _____ | |

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

|_| |_| |_| |_| |_| |_| |_| |_| |_| |_| |_|

Have you had spine surgery?

- Yes – 1 Operation Yes – 3 Operations Yes—5 Operations
- Yes—2 Operations Yes—4 Operations No—I have not had surgery.

Please List:

Operation	Hospital	Date	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any previous back or neck injury: _____

Have you had nerve blocks (injections) for pain relief? Yes No

If **yes**, did it help? Yes No

Have you had physical therapy for pain? Yes No

If **yes**, did it help? Yes No

Have you had Tens Unit for your pain? Yes No

If **yes**, did it help? Yes No

Name of Doctor that performed blocks? _____

List **ALL** (including over the counter) medications you have had for pain: _____

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

16. Are you employed now?

- Yes – Full Time On Sick Leave
- Yes – Full Time with Restrictions No, but not because of pain
- Yes – Part Time No, unable to work because of pain
- Yes – Part Time with Restrictions Disabled

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

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

19. Any previous work injuries? Yes No

20. Have you ever applied for disability? Yes No

21. Are you involved in or considering a lawsuit? Yes No

If **yes**, name of your attorney. _____

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

26. 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:

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