VICTORY MEDICAL & WELLNESS CENTER
Initial Pain Management Questionnaire

Name: _______________________________________ Age: ______ Date of Birth: ___/____/20____

Rsvd 1/12/2011

Please tell us in one sentence why you are here. (e.g. "My back huts.")

____

How bad is the pain WITHOUT ANY MEDICATION? (PLEASE CIRCLE ONE)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please place an 'X' on the painful area and which words describe the pain? (PLEASE CHECK ALL THAT APPLY)

__Throbbing Continuous – Intermittent
__ Aching Continuous – Intermittent
__ Sharp Continuous – Intermittent
__ Dull Continuous – Intermittent
__ Shooting Continuous – Intermittent
__ Tingling Continuous – Intermittent
__ Burning Continuous – Intermittent
__ Numbness Continuous – Intermittent
__ Hot Continuous – Intermittent
__ Cold Continuous – Intermittent

How long have you had the pain? __________ Years / Months (PLEASE CIRCLE ONE)

What caused the pain? (PLEASE CHECK ONE)

__ Motor Vehicle Accident __ Fall __ Lifting __ Unknown __ Other _________________________

What therapies have you TRIED in the past to relieve pain?

WHETHER IT WORKED OR NOT PLEASE CHECK ALL THAT APPLY

__ Non-Steroidal Anti-Inflammatory Medications

Such as Motrin, Naproxen, Celebrex, INCLUDING OVER THE COUNTER MEDS like Ibuprofen, Aleve, Aspirin, etc….

__ Physical Therapy **__ Massages** **__ Chiropractor**
__ Injections in the neck or back **__ Bio-Feedback** **__ Psychologist or Psychiatry Care**

Do you drink alcohol? __Yes __ No If yes, How much do you drink? ________ a day / week.
Do you use tobacco? __ Yes __ No If yes, How much do you use? __________ a day / week.
Have you ever had any problems with addiction or substance abuse? __ Yes __ No
How many hours of activity do you have during a 24-hour period? ___________

Are you allergic to any medications? _No _Yes, ___________________________

List <u>ALL</u> medications you are taking for your pain <u>AND</u> your medical problems?

Medication Name	Amount Take	Prescribing Physician	Medical Problem
________________	_______________	________________	__________________
________________	_______________	________________	__________________
________________	_______________	________________	__________________
________________	_______________	________________	__________________

Tell us if you have:

(check all that apply)

__Worries 1
__Anticipates worst
__Startles or easily cries 2
__Fear of the dark, strangers, being alone or of animals. 3
__Difficulty falling or staying asleep
__Difficulty with nightmares 4
__Poor concentration
__Memory impairment 5
__Decreased interest in activities 6
__Less pleasure from favorite activities
__Grinding your teeth at night 7
__Ringing in your ears 8
__Tachycardia or "Racing Heart"
__Palpitations or "Skipped Beats"
__Chest pains
__Feeling like going to faint 9
__Shortness of breath without walking
__Shortness of breath with walking
__Choking 10
__Problems swallowing
__Nausea
__Diarrhea
__Vomiting
__Constipation
__Weight loss 11
__Urinary frequency or urgency
__Female Menstrual Cycle Problems
__Impotence 12
__Dry mouth

__Flushing of the face at times
__Paleness of the face on at times sweating 13
__Seizures
__Stroke
__Difficulty hearing AA
__Swelling of the ankles
__Jaundice BB
__Anxiety
__Mole changes
__Kidney problems or on dialysis
__Schizophrenia
__Hoarseness
__Black or tarry stools CC
__Easy bruising
__History of liver problems
__History of hepatitis
__Asthma
__Bleeding disorder
__Bronchitis or COPD
__Lymph node swelling DD
__Diabetes
__History of heart attack
__Thyroid disorder
__High blood pressure EE
__Cancer

What brings on your pain or makes it worse? (e.g. walking, coughing)
____
____

What makes your pain better? ____
____

Are you ever pain free? ☐ Yes ☐ No
____

How does the pain limit your activities?____
____

What would you do if you did not have pain?_____________________________________
____

How does the pain affect your sleep?____
____

Are you currently working? ☐ Yes ☐ No

What is your usual occupation____

If no, when did you last work?____

Please list all surgeries you have had. Please list any serious Illnesses you have had.

Surgery/Operations Date

____
____
____

Illnesses/Hospitalizations Date

____
____
____

Please list your Family History. (e.g. Cancer, Heart Attack, Stroke.)

Mother____
Father____
Grandmother____
Grandfather____

*****I confirm that I am not a hazard to myself or others. (Please Initial)_________*****

Signature____________________________________Date_______________________