

SANFORD M. SILVERMAN, MD, PA

Comprehensive Pain Medicine
Spinal Diagnostics & Therapeutics

PAIN MANAGEMENT QUESTIONNAIRE

We photograph all patients at the first visit. This is for our records only and is not distributed to anyone for research, publication or any other use.

DATE _____

Please read the following carefully and answer all the questions to the best of your ability. If does not apply, please indicate N/A. They will help us in better treating your pain. Thank you for your time and consideration.

NAME _____

AGE _____ LAST _____ HEIGHT _____ FIRST _____ WEIGHT _____

Referring Physician(s) _____

Other Physicians seen for this problem _____

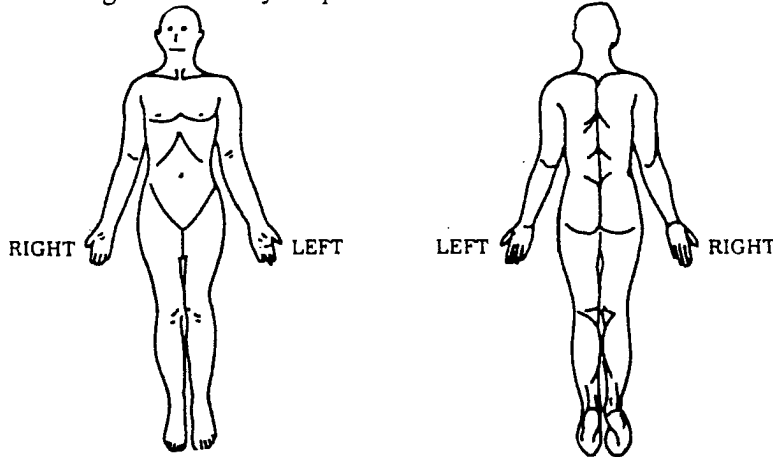
Allergies or adverse reactions to MEDICATIONS , IODINE OR CONTRAST , SHELLFISH _____

HOW LONG HAVE YOU HAD THIS PAIN? _____

How would you rate your pain on the scale below with 0 being no pain and 10 being the worst pain imaginable?

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

Please shade in the areas on the diagrams where your pain is located.



Please circle the appropriate words that best describe your pain.

- | | | | |
|----------|----------|-----------|--------------|
| ACHING | SHOOTING | DULL | CONSTANT |
| BURNING | TINGLING | TIGHT | RADIATING |
| CRAMPING | HOT | HEAVY | ANNOYING |
| NUMBING | COLD | INTENSE | SEVERE |
| STINGING | SORE | BRIEF | UNBEARABLE |
| STABBING | SHARP | TRANSIENT | EXCRUCIATING |

1. Is your pain the result of an

illness
accident

YES

NO

2. Are you presently involved in litigation or a law suit resulting from this accident? YES NO

If yes, what is the name of your attorney _____

3. Please indicate if the following **increases, decreases** or causes **no change** in your pain.

	INCREASES PAIN	DECREASES PAIN	NO CHANGE
LIQUOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STIMULANTS (coffee, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EATING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COLD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DAMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WEATHER CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MASSAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SLEEP, REST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYING DOWN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SITTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEXUAL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DISTRACTION (TV, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BOWEL MOVEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BRIGHT LIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOUD NOISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SNEEZING, COUGHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you have difficulty sleeping? NO YES How many hours do you sleep at night? _____

5. Do you smoke? NO YES If so, how much and how long? _____

6. How much coffee or caffeinated beverages (tea, cola, etc.) do you drink daily? _____

7. How much beer or alcoholic beverages do you drink daily? _____

8. Do you drive a car with automatic transmission manual transmission

9. Do you sleep on water bed traditional mattress

10. What is your usual occupation? _____

11. Are you presently working? YES NO

12. Please indicate which diagnostic tests (procedures) you have had, in addition to where and when they were performed.

	YES	NO	DATE	LOCATION
X-RAY	<input type="checkbox"/>	<input type="checkbox"/>		
EMG	<input type="checkbox"/>	<input type="checkbox"/>		
MRI	<input type="checkbox"/>	<input type="checkbox"/>		
CT SCAN	<input type="checkbox"/>	<input type="checkbox"/>		
BONE SCAN	<input type="checkbox"/>	<input type="checkbox"/>		
MYELOGRAM	<input type="checkbox"/>	<input type="checkbox"/>		

13. Please check any of the following treatments you have had for this pain problem, including the dates and results.

PAIN RELIEF

TREATMENT	YES	YES	NO	DATE DONE
NERVE BLOCKS.				
EPIDURAL STEROIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TENS UNIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TRACTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ACUPUNCTURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHIROPRACTOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN CLINIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PSYCHIATRIST, PSYCHOLOGIST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HYPNOSIS, BIOFEEDBACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

14. Please list ALL MEDICATIONS (prescription & over-the-counter) you are currently taking. Please indicate the doctor who prescribed them.

MEDICATION / DOSE	REASON TAKEN	HOW OFTEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. ARE YOU CURRENTLY TAKING OR HAVE YOU RECENTLY TAKEN ASPIRIN, VITAMIN E, GINKO BILOBA? YES__ NO__ IF YES, WHAT DOSE _____

16. Have you ever taken or been given: WHEN? ANY PROBLEMS

	YES	NO	
Anti-coagulants (blood thinners - coumadin, heparin)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cortisone or steroids _____
 Local anesthetic (by doctor or dentist) _____

17. Please list all surgeries you have had, when, and name of surgeon.

SURGERY	DATE	SURGEON
_____	_____	_____
_____	_____	_____
_____	_____	_____

18. Please check the appropriate space if you have had or presently have any of the following health problems.

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy (Seizures) | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Vascular Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes Zoster (Shingles) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ |

19. Please list any significant medical problems in your family, including parents and siblings.

20. Have you ever been treated for or had a history of addiction to alcohol or controlled or illicit substances?

- Yes No If yes, give details:

21. ADDITIONAL COMMENTS: Please add any comments which you feel would help in treating your pain.

Please answer the following questions using the following scales:

0 = NEVER 4 = VERY OFTEN

1. How often do you have mood swings? _____
2. How often have you felt the need for higher doses of medication to treat your pain? _____
3. How often have you felt impatient with your doctors? _____
4. How often have you felt that things are just too overwhelming that you cannot handle them? _____
5. How often is there tension in the home? _____
6. How often have you counted pain pills to see how many are remaining? _____
7. How often have you been concerned that people will judge you for taking pain medication? _____
8. How often do you feel bored? _____
9. How often have you taken more pain medication than you were supposed to? _____
10. How often have you worried about being left alone? _____
11. How often have you felt the craving for medication? _____
12. How often have others expressed concern over your use of medication? _____
13. How often have any of your close friends had a problem with alcohol or drugs? _____
14. How often have others told you that you have a bad temper? _____
15. How often have you felt consumed by the need to get pain medication? _____
16. How often have you run out of pain medication early? _____
17. How often have others kept you from getting what you deserve? _____
18. How often, in your lifetime, have you had legal problems or been arrested? _____
19. How often have you attended an AA or NA meeting? _____
20. How often have you been in an argument that was so out of control that someone got hurt? _____
21. How often have you been sexually abused? _____
22. How often have others suggested that you have a drug or alcohol problem? _____
23. How often have you had to borrow pain medications from your family or friends? _____
24. How often have you been treated for an alcohol or drug problem? _____

TOTAL SCORE: _____