

# Orthopedic Associates of Dutchess County, P.C.

## Pain Questionnaire

The purpose of this questionnaire is to obtain a complete assessment of you and your pain problems. This is a long questionnaire because pain is a very complex problem that affects all aspect of your life. We are trying to evaluate how the pain has affected your life so that we can make the best recommendation possible to assist you in your recovery. This record is confidential and no one can see it without your permission.

Patient's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

Acct#: \_\_\_\_\_ Date: \_\_\_\_\_

Signature/Relationship of person completing this form: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Phone: (Home): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Referring Physician's name and address: \_\_\_\_\_

\_\_\_\_\_ Phone#: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving or in the process of receiving worker's compensation related to your problem? YES NO

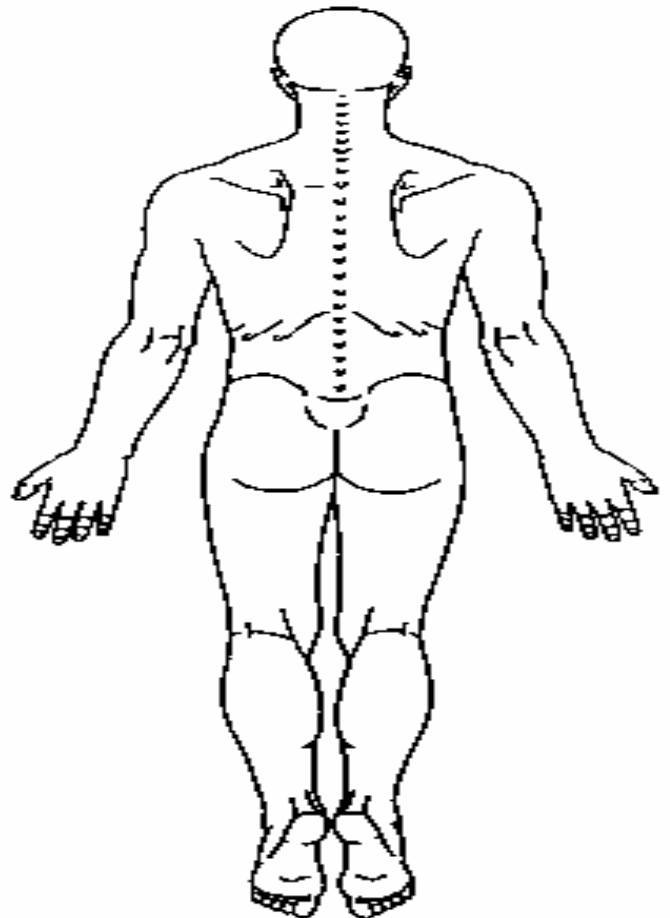
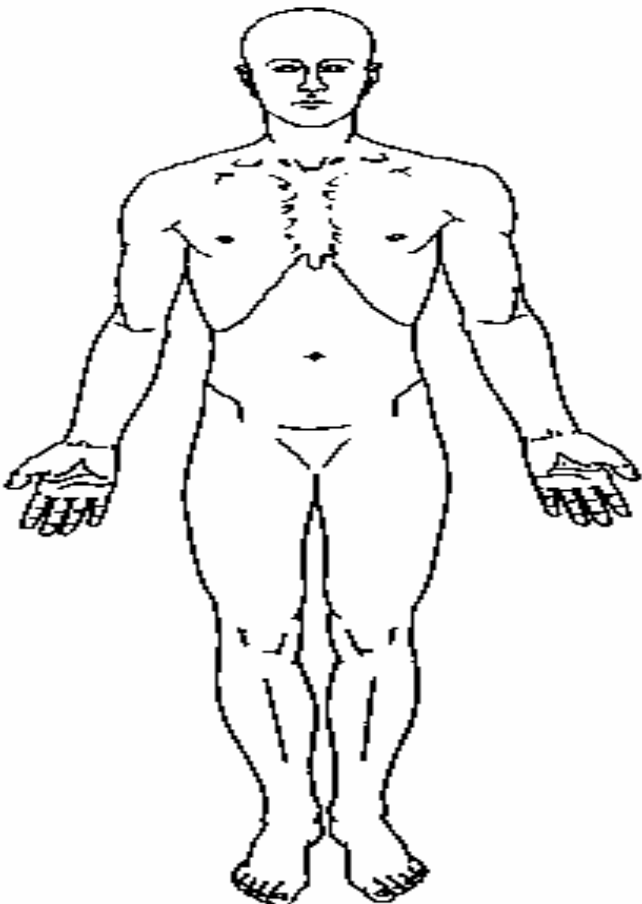
Are you involved in litigation related to your pain problem? YES NO

### Pain Diagram

Pain: + + +

Numbness: - - -

Tingling: x x x



Pain History (Circle ones that apply)	Pain Intensity (Circle the one that applies)
Throbbing, Shooting, Stabbing, Sharp, Cramping, Gnawing, Hot burning, Aching, Numbness, Tingling, Dull, Pulling	0 1 2 3 4 5 6 7 8 9 10 <b>0= No Pain 5= Moderate Pain 10= Worst Pain</b>  Number your pain when it is worst: _____ Number your pain when it is least: _____ Number your pain on average: _____

When did the pain begin?: \_\_\_\_\_

How did your pain begin?: \_\_\_\_\_

Briefly describe the circumstance when your pain began: \_\_\_\_\_

In general, when is your pain the worst?

Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_ Night \_\_\_\_\_ No pattern to the pain \_\_\_\_\_

How often do you have the pain?

Constantly (100% of time) \_\_\_\_\_ Nearly constantly(60-95% of time) \_\_\_\_\_

Intermittent (30-60% of time) \_\_\_\_\_ Occasionally(less than 30% of time) \_\_\_\_\_

Please circle what makes your pain feel:

Worse: Walking Lifting Bending Lying Weather changes Standing Other: \_\_\_\_\_

Better: Heat Ice Rest Lying Weather changes Standing Medication: \_\_\_\_\_

**Prior Treatments (Check all that apply)**

	Helpful	Not Helpful
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Nerve Block	<input type="checkbox"/>	<input type="checkbox"/>
TENS	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>
Psychology support	<input type="checkbox"/>	<input type="checkbox"/>

**Diagnostic procedure done**

Diagnostic Test	Body part evaluated	Date
Plain X-Rays		
MRI		
CT Scan		
EMG		
Bone Scan		
Discogram		
Myelogram		

**Past Medical History**

- Heart Problems\_\_\_\_\_
  - Hypertension\_\_\_\_\_
  - Circulation Problems\_\_\_\_\_
  - Diabetes\_\_\_\_\_
  - Kidney/Bladder Problems\_\_\_\_\_
  - Liver Problems\_\_\_\_\_
  - Cancer\_\_\_\_\_
  - Blood Disorders\_\_\_\_\_
  - Lung Problems/Asthma\_\_\_\_\_
  - Intestinal Problems/Ulcers\_\_\_\_\_
  - Blackouts/Falls\_\_\_\_\_
  - Other\_\_\_\_\_
  - Any medical Devices implanted in your body?\_\_\_\_\_
- (i.e., pacemaker, portacath, pump, rods, prosthesis, etc.)

**Past Surgical History**

Name of Surgery	Date

**Please list all medication and dosages you are currently taking. PLEASE DO NOT OMIT any blood thinners you may be taking; i.e., Coumadin, Lovenox, Heparin, Plavix, Aggranox, etc.**

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**Please list all drug allergies**

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**Social History**

Significant other: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you take care of other family members: \_\_\_\_\_

Previous/Current Occupation: \_\_\_\_\_

Are you currently working? YES NO If not, why?\_\_\_\_\_

Do you have any legal issues that are current or pending related to your current medical problem? YES NO  
If yes, please specify\_\_\_\_\_

Do you smoke? YES NO If yes, how many per day?\_\_\_\_\_

Recreational drug use? YES NO

Alcohol use? YES NO If yes, how many per day/week\_\_\_\_\_

**Family History**

Do you have a family history of the following. Please circle the ones that apply.

Pain Arthritis Cancer Psychological problems Bleeding disorders Other \_\_\_\_\_  
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**Patient's review of systems (Circle the ones that apply to you)**

**Constitutional:** Wt. \_\_\_\_\_ Ht. \_\_\_\_\_ Fever/Chills Night sweats Wt. Loss Wt. Gain

**HEENT:** Hearing loss Hearing aid R/L Sinus problem Loose teeth Dentures partial/full  
Glaucoma/Cataracts Glasses/Contacts

**Endocrine:** Diabetes Insulin dependent/oral diabetic medications Thyroid problems Addison's disease  
Excessive thirst or urination

**Respiratory:** Blood in sputum Shortness of breath Chronic cough Snoring Home oxygen  
Home breathing treatment Airway obstruction History of TB Sleep apnea Nasal septal deviation

**Cardiovascular:** Angina Chest pain Palpitations Heart murmur (if yes, do you take antibiotics for  
dental work?) Heart attack Chronic heart failure Shunts/Stents Rheumatic fever Pacemaker  
Artificial valve

**Gastrointestinal:** Change in appetite Hepatitis Liver disease Ulcer Heartburn Diarrhea  
Constipation Nausea/vomiting Gastrointestinal bleeding (blood in stool, dark/tarry stool, vomiting blood)  
Bowel incontinence

**Gynecological:** Last period \_\_\_\_\_ Menopausal Hysterectomy

**Genitourinary:** Kidney problems Burning while urinating Blood in urine Frequency  
Bladder or Kidney infections Ostomy Dialysis Catheter Difficulty urinating Urinary incontinence

**Neurological:** Dizziness Headache Seizures Stroke Weakness of extremities Fainting Numbness  
Paralysis Multiple sclerosis Other: \_\_\_\_\_

**Hematological:** Easy bruising Low platelets On Asprin/Non steroid anti-inflammatory  
History of cancer History of radiation therapy History of chemotherapy

**Musculoskeletal:** Back pain Neck pain Joint pain Arthritis Cast Osteoporosis Amputation  
Joint replacement Artificial limb Rheumatoid arthritis

**Skin:** Sores Rashes Bruises Cuts Burns Incision Itching

**Psychological:** During the past month have you been- Tense Anxious Depressed Discouraged  
Irritable Upset