PAIN RELIEF
OF DAYTON

Interventional Pain Medicine
for Spine & Chronic Pain Care
Board Certified • Fellowship Trained

www.painreliefofdayton.com

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Pain Questionnaire & Medical History

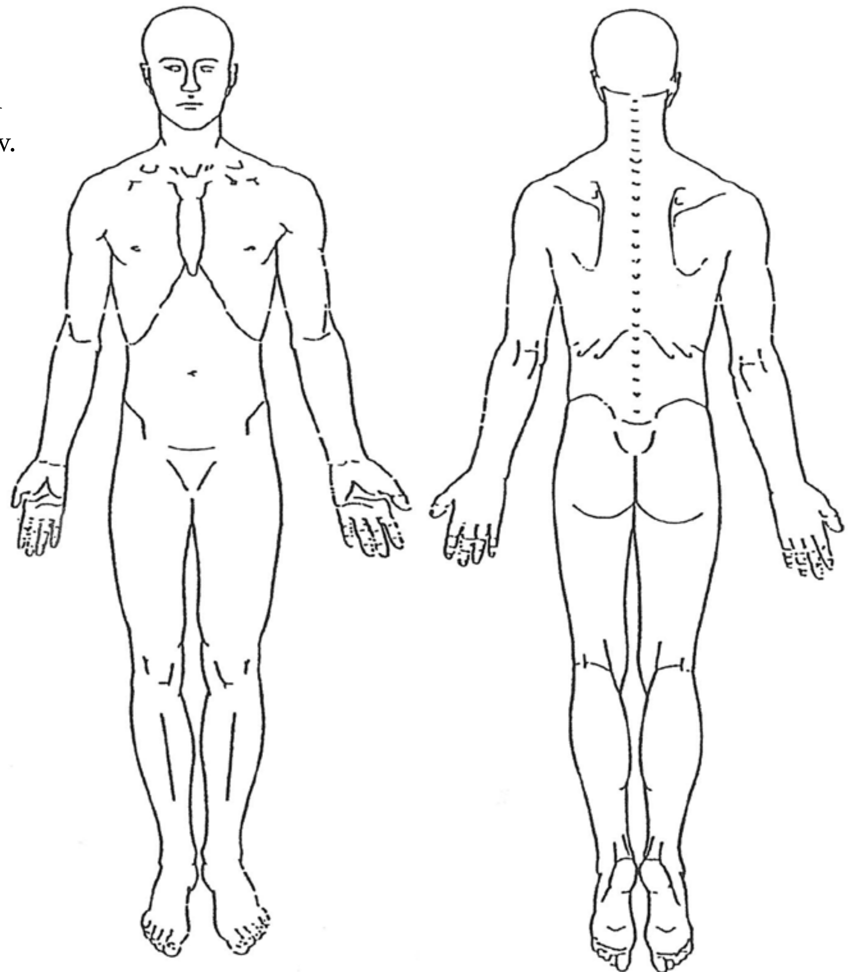
Name ______________________

Date ______________________

Your Age ______________________

If you have scheduled an appointment with us, go to the Treatment page on our website www.painreliefofdayton.com for the downloadable patient information form that you can also fill out prior to your appointment — to save you time.

Where is your pain located? And does it radiate to other parts of your body? Please circle the problem areas on diagram and provide written details below.



What best describes your pain. Check all that apply:

☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Radiating
☐ Cramping ☐ Pulling ☐ Burning ☐ Itchy ☐ Cold
☐ Aching ☐ Tender ☐ Tiring ☐ Sickening ☐ Numb
☐ Terrifying ☐ Grueling ☐ Blinding ☐ Miserable ☐ Nauseating

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When did your pain start? Has it worsened over time?

What triggered your pain?

- ☐ Accident at work
- ☐ Accident at home
- ☐ Other accident
- ☐ Following an illness
- ☐ Following surgery
- ☐ Pain just began

In the space below, please elaborate on the circumstances that triggered your pain.

Are you experiencing any numbness, tingling or weakness?

What best describes your pain? Check what applies:

- ☐ Continuous, steady, constant
- ☐ Rhythmic, periodic, intermittent
- ☐ Brief, momentary, transient

Is your pain associated with any other symptoms? Check what applies:

- ☐ Nausea
- ☐ Dizziness
- ☐ Constipation
- ☐ Diarrhea
- ☐ Headache
- ☐ Menses
- ☐ Urination
- ☐ Other (please list): ____________________

Are you experiencing any bowel or bladder incontinence problems?

Please rate your pain from 0 (No pain) to 10 (Worst pain possible):

_______ Now
_______ Average pain score
_______ At its lowest this past week
_______ At its worst this past week

Following is a list of things that may improve or worsen your pain.
Please check the appropriate column as it affects your pain.

Improves		Worsens
	Liquor	
	Stimulants (coffee, etc.)	
	Eating	
	Heat	
	Cold	
	Damp	
	Weather	
	Massage	
	Pressure	
	No movement	
	Movement	
	Rest/Sleep	

Improves		Worsens
	Lying down	
	Distraction	
	Urination	
	Defecation	
	Tension	
	Lights	
	Loud noises	
	Going to work	
	Sexual Intercourse	
	Mild exercise	
	Fatigue	

How does pain affect your sleep? Check what applies:

- ☐ Trouble falling asleep
- ☐ Medication needed to fall asleep
- ☐ Awakened by pain

Does your pain affect desire and ability for sexual relations? Check what applies:

	No Change	Decreased	Gone
Desire			
Ability			

When is your pain worst?

☐ morning ☐ noon ☐ evening ☐ night

Does your pain worsen with:

☐ sitting ☐ standing ☐ lying

What is your occupation?

How does your pain affect your ability to work?

Do you occasionally stop all work activities because of your pain? ☐ Yes ☐ No
If yes, please tell us how many times each:
_______ Day
_______ Week
Additional Comments:

Has your food intake changed since the onset of pain? ☐ Yes ☐ No
If yes, please describe:

Please list the physicians names you have seen for your pain condition:

What medications have you tried for pain relief, but no longer use?

What treatments, therapy, injections or surgeries have you received for your pain?

What, if any, alternative therapy treatments (e.g. acupuncture, massage, chiropractic, hypnosis, prolotherapy) have you undergone for your pain?

Have you ever received psychiatric or psychological counseling for your pain condition?
If yes, please describe:

Please tell us about your other medical conditions. Do you suffer from any conditions related to or containing? Circle all that apply:

Brain – stroke, seizure, headache, migraine
Nerves – neuropathy, neuralgia
Heart – hypertension, angina, arrhythmia, congestive heart failure
Lung – asthma, emphysema, smoker
GI – ulcers, reflux, irritable bowel, Crohn's disease
GU – kidney stones, dialysis, interstitial cystitis, endometriosis, chronic pelvic pain
Liver – hepatitis, cirrhosis, gall stones
Endocrine – diabetes, pancreatitis, thyroid disease
Cancer
Alcohol or substance abuse
Arthritis, lupus, osteoporosis, fibromyalgia
Blood disorders, clotting disorders, anemia, sickle cell disease
Psychiatric / Behavioral – depression, mania, anxiety, schizophrenia, personality disorder
Infectious Diseases – HIV, Hepatitis B, Hepatitis C

Do you suffer from any other medical conditions?

Please list all your previous surgeries:

Have you or any family member ever experience any problems when receiving general or local anesthesia?

Have you ever received any psychiatric or psychological counseling? If yes, please describe:

Family History

Do your parents, siblings and/or children suffer from any chronic illnesses? Please list:

Do your parents, siblings and/or children suffer from any chronic pain conditions? Please list:

Social History

What is your highest education level or grade attained?

- ☐ High School Graduate ☐ College Graduate
- ☐ Some High School ☐ Some College
- ☐ Professional

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Total number of children:

Please tell us all the people living in your home now. Please list their ages and relationship to you:

Are you working? ☐ Yes ☐ No

If yes, what kind of work do you do? And is it full-time or part-time?

If you are not working, are you:

- ☐ Retired ☐ Looking for Work
- ☐ Unemployed ☐ Disabled

Do you receive disability benefits? ☐ Yes ☐ No

Are these benefits: ☐ Partial ☐ Total

Are these benefits: ☐ Temporary ☐ Permanent

Are you involved in any legal proceeding related to your pain problem? ☐ Yes ☐ No

If yes, is this related to:

- ☐ Disability ☐ Medical Malpractice
- ☐ Personal Injury ☐ Worker's Compensation

Do you use any of the following? Please check all that apply:

- ☐ Tobacco – What type and how much?
- ☐ Alcohol – What type and how often?
- ☐ Illicit Drugs – Which and how often?

Has a person who knows you ever suggested you seek evaluation or treatment for any substance abuse?

Medical History

Please list all the doctors and dentists who treat you now, their specialty and phone number:

Please list all the medications you are now taking, their strength and how often you take them.

Pain Medication:

Anti-Inflammatory Medication:

Anti-Seizure or Nerve Pain Medication:

Anti-Depressant Medication:

Muscle Relaxants:

Anti-Anxiety or Nerve Pill:

Blood Thinners:

Other Medications:

Nutritional or Herbal Supplements:

Please list all your allergies to medications and non-medications:

Review of Systems

Please check any symptoms or complaints you have of the items on this list:

General
- ☐ Disturbed sleep
- ☐ Weight Gain or Loss
- ☐ Fever or Sweats
- ☐ Chronic Fatigue

Eyes
- ☐ Cataracts
- ☐ Blurred or Double Vision
- ☐ Glaucoma

Head & Neck
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Balance Problem
- ☐ Swollen Glands

Cardiovascular
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Swelling or Edema
- ☐ Heart Trouble

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Loose Stool
- ☐ Constipation
- ☐ Rectal Bleeding

Genitourinary
- ☐ Frequency
- ☐ Urgency
- ☐ Hesitancy
- ☐ Bloody or Rusty Urine
- ☐ Sexual Problems
- ☐ Menstrual Problems (women)
- ☐ Testicular Pain (men)
- ☐ Pregnant (women)

Musculoskeletal
- ☐ Bone Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Trouble Walking

Skin
- ☐ Rash
- ☐ Redness
- ☐ Eczema or Psoriasis

Neurologic
- ☐ Seizures
- ☐ Weakness
- ☐ Paralysis
- ☐ Numbness

Psychologic
- ☐ Depression
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Panic Attacks

Endocrine
- ☐ Thyroid
- ☐ Diabetes
- ☐ Steroid Use

Blood & Immune
- ☐ Bruising
- ☐ Clots
- ☐ Hemophilia
- ☐ Anemia

Allergy & Immunology
- ☐ Seasonal Allergies
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immune Deficiency

All the above is the truth to the best of my knowledge.

Patient Signature ______________________________ Date ____________________

The above has been reviewed by a physician.

Physician Signature ______________________________ Date ____________________