THE PAIN CENTER
OF WEST VIRGINIA
COMPREHENSIVE PAIN CARE

Patient Questionnaire:

Name: _____ Date:_____
Occupation: _____

Date of Birth: _____ Age:_____ Sex: ☐Male ☐Female

Referring Physician: _____

Chief Complaint:

_____
_____
_____
_____

Describe your Pain:
☐ sudden onset ☐ gradual
☐ constant ☐ intermittent
☐ worsening ☐ improving
☐ sharp ☐ shooting ☐ electric-like ☐ stabbing ☐ dull ☐ achy ☐ deep
☐ radiates (travels) to: ☐arms ☐ legs ☐ Other:

Severity: ☐ minor ☐ moderate ☐ severe

Intensity: 0-10 (10 is the worse pain you have ever experienced in your life that you would want to jump from a building, 0 is no pain) _____

What makes your pain ***worse?:***
☐standing ☐sitting ☐bending forward ☐bending backward ☐ side bending ☐ twisting
☐sneezing ☐coughing ☐walking ☐stress ☐touching of the skin ☐cold weather
☐During exercise ☐after exercise

What makes your pain ***less (better)?***
☐standing ☐sitting ☐bending forward ☐bending backward ☐walking ☐stress
☐cold (ice) ☐exercise ☐injections ☐pain medication ☐alcohol ☐Physical therapy

What treatments have you tried?
☐Medications ☐Physical Therapy ☐Acupuncture ☐injections ☐psychology/counseling
☐TENS Unit ☐Chiropractor ☐Pain Management Services Elsewhere
Please specify your response _____

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What diagnostic tests have you undergone?

A) ☐Imaging → ☐MRI ☐CT ☐X-ray
B) ☐EMG/NCV
C) ☐Interventional procedures

Past Medical History:

PLEASE LIST ALL ALLERGIES including medications, foods and any others:

_____

_____

Medication(s)	Dose	Frequency (how often do you take)	Duration

Are you on a blood thinner? ☐YES ☐NO
If yes please specify? _____

In the past have you had any of the following medical problems? (Please check all that apply to you.)

Cardiovascular

☐Arrhythmia (irregular heartbeat)
☐Coronary artery disease
☐Congestive heart failure
☐Hyperlipidemia (high cholesterol)
☐Hypertension (high blood pressure)
☐Myocardial infarction (heart attack)
☐Poor circulation
☐Other_____

Pulmonary

☐Asthma
☐COPD (chronic obstructive pulmonary disease)
☐Chronic bronchitis
☐Tuberculosis
☐Other_____

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Gastrointestinal

☐Cholelithiasis (gallstones)
☐Cirrhosis
☐Colon polyps
☐GERD (gastroesophageal reflux disease, indigestion)
☐Peptic ulcer disease
☐Other_____

Renal/Genitourinary

☐BPH (benign prostatic hypertrophy)
☐Endometriosis
☐Kidney disease or stones
☐Renal failure

☐Urinary incontinence or retention
☐Other_____

Musculoskeletal/Connective Tissue

☐Chronic pain
Specify_____
☐Fibromyalgia
☐Fractures
Specify:_____
☐Osteoarthritis
☐Osteoporosis

☐Rheumatoid arthritis
☐Other_____

Endocrine

☐Diabetes ☐Type I ☐Type II

☐Hyperthyroidism
☐☐Hypothyroidism

☐Other_____

Hematologic

☐Anemia
☐Other_____

Neurologic

☐Carotid stenosis
☐CVA (stroke, TIA)
☐Headaches Migraine Tension
☐Multiple sclerosis
☐Parkinson's disease
☐Seizure disorder
☐Other_____

Psychiatric

☐Anxiety
☐Bipolar disorder
☐Depression
☐Obsessive/Compulsive disorder
☐Post-traumatic stress disorder

☐Other_____

Cancer - Specify location and types of treatment:

_____

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Past Surgical History:

☐**I have never had surgery.**
☐Angioplasty
☐ Coronary Artery Stent
☐Appendectomy
☐Fracture
☐Arthroscopy _____
☐Hernia repair Location_____
☐Hysterectomy
☐Carotid endarterectomy ☐Right ☐Left
☐Cataract extraction ☐Right ☐Left
☐Cholecystectomy (gall bladder removal)
☐Coronary artery bypass graft
☐Joint replacement_____
☐Pacemaker
☐Spine surgery
☐Tonsillectomy/Adenoidectomy

Social History

Smoking Status
Do you smoke? ☐Yes ☐ No If yes, what is your usage per day: _____
Alcohol
Do you drink alcohol: ☐Yes ☐ No If yes, how much do you drink per week:_____
Illicit Drugs
Do you use any illicit drugs? ☐Yes ☐ No If yes, please explain:_____

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Family Medical History: Please check if a family member has had any of the following medical problems:

	Father	Mother	Brother	Sister
Cardiovascular:	☐	☐	☐	☐
Endocrine:	☐	☐	☐	☐
Gastrointestinal:	☐	☐	☐	☐
Genitourinary:	☐	☐	☐	☐
Hematologic(blood)	☐	☐	☐	☐
Musculoskeletal:	☐	☐	☐	☐
Neurological:	☐	☐	☐	☐
Psychiatric:	☐	☐	☐	☐
Pulmonary:	☐	☐	☐	☐
Cancer: Specify Type:	☐	☐	☐	☐
Other: Specify Type:	☐	☐	☐	☐

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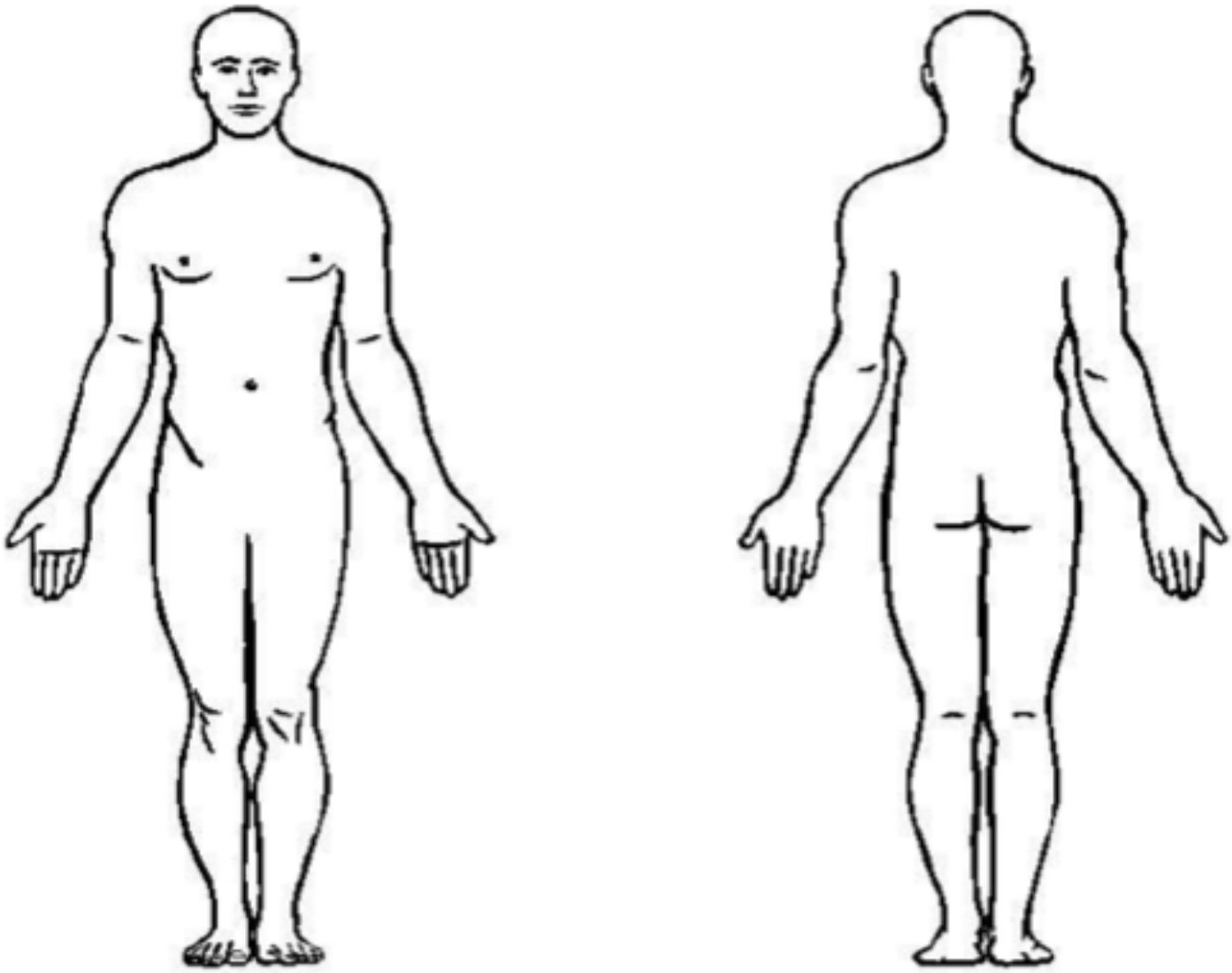
Please indicate the area of your pain:

Draw an: X - to indicate areas of deep pain Z- to indicate areas of tingling/numbness

Use arrows to show areas that pain/tingling radiates (travels)



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