



Orthopaedic Specialists of North Carolina Pain Questionnaire



Please complete this form before seeing Dr. Watson at your first appointment. Your answers will help us understand your pain problem and plan the best treatment program for you.

Name: _____ Date: _____ Age: _____
First MI Last

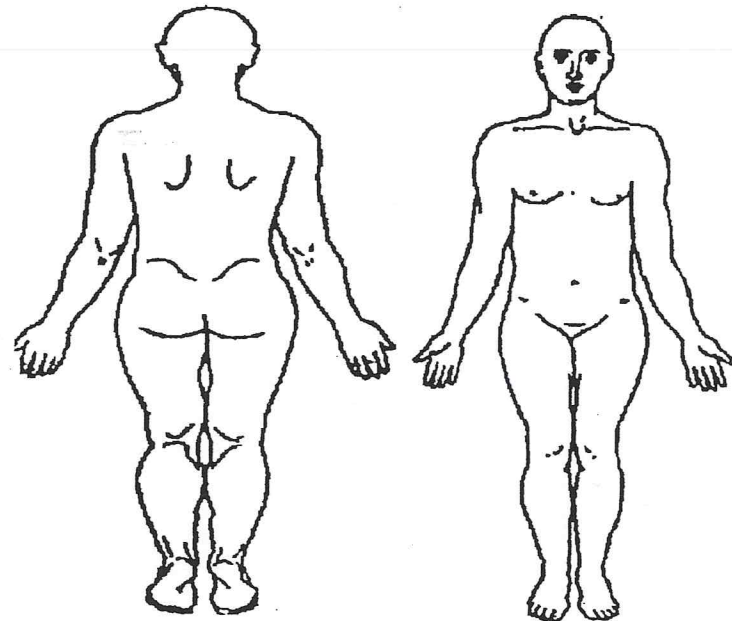
Family Physician: _____ Referring Physician: _____

Please tick any of the words that describes your pain under the column that describes it's intensity.

PLEASE DRAW YOUR PAIN

xxx	Burning	==	Numbness
!!	Stabbing	**	Cramping
00	Aching	##	Other

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				



Rate your pain: (Tick along the scales below)

Today – No Pain [_____] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

On Most Days – No Pain [_____] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

At It's Worst – No Pain [_____] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

At It's Best – No Pain [_____] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

When is your pain the worst? (Please check one)

- | | | |
|------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Morning | <input type="checkbox"/> Evening | <input type="checkbox"/> No regular pattern |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Night | |

How long have you had this pain (in weeks/months/years) before this visit? _____

How did your pain originally begin? (Please check one)

- Accident/Injury at work For no apparent reason Related to an illness
 Accident/Injury at home Following surgery Other: _____

How many hours per day are you in pain? _____ How many hours do you sleep each night? _____

How many days per week are you in pain? _____ Does your pain wake you at night? Yes / No

How many weeks per year are you in pain? _____ Do you feel rested during the day? Yes / No

Have you previously been seen by a pain specialist? Yes / No Who/Where? _____

How do the following affect your pain? (Please check one for each item)

	Decreases	Has No Effect	Increases
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Passing urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions	<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"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Circle any treatments that have been tried for this pain before:

- | | | |
|-----------------------------|--------------------------|--------------------------|
| Acupuncture | Bedrest | Spinal cord stimulation |
| Biofeedback | Medication | Surgery |
| Chiropractor | Orthotics (braces) | TENS unit |
| Epidural Steroid Injections | Physical Therapy | Traction |
| Exercise | Psychotherapy/Counseling | Trigger point injections |
| Heat or Cold treatment | Pool/Aqua Therapy | Ultrasound |

Functional History:

Please rate the effect your pain has on the activities listed below by marking on each line:

General activities of living:

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Your Mood:

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Ability to walk:

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Ability to Work: (including both inside and outside the home)

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Relationships with other people:

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Sleep:

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Enjoyment of Life:

No Effect [_____] Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Please mark your top three goals for seeking care for your pain (1 = most important – 3 = least important)

- | | |
|------------------------------------|----------------------------|
| _____ Complete pain relief | _____ Better relationships |
| _____ Partial pain relief | _____ Improved mood |
| _____ Reduced medication use | _____ Reduced tension |
| _____ Increased job activities | _____ Not sure about goals |
| _____ Increased general activities | _____ Other: _____ |

Do you currently use any adaptive equipment? (Circle all that apply):

Walker Cane Wheelchair Elevated toilet seat Ramp

Work History:

Present job situation (Check one):

- | | | | |
|------------------------------------|-------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Full time | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Leave of absence | <input type="checkbox"/> Student |
| <input type="checkbox"/> Part time | <input type="checkbox"/> Retired | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Disabled |

What is your current work or your last job if you are not currently working?

If you are working full or part time, when did you return to work? (Date) _____

If you are not working what was your last day of work? (Date) _____

Would you return to work if you had less pain? Yes No

Have you tried to return to work? Yes No

Social History:

Marital Status (Circle one):

Single Separated Married Divorced Remarried Widowed

Number of children: _____

Present living arrangements (Circle all that apply):

Alone Spouse Children Parents Other family members

Substance intake:

- a. Caffeine (coffee, tea, cola, mountain dew, energy drinks, etc.) _____ (per day)
- b. Nicotine (cigarettes, cigar, pipe, chewing tobacco, snuff, etc.) _____ (per day)
- c. Alcohol (beer, liquor, wine, etc) _____ (per week)

Have you recently used any of the following drugs? (Circle all that apply)

Marijuana Cocaine Heroin Ecstasy None of these Other

Have you ever felt the need to cut back on your drinking or drug use? Yes No

Have you ever been annoyed by someone questioning your use of alcohol or drugs? Yes No

Have you ever felt guilty about something you did while drinking or using drugs? Yes No

Have you ever had to drink alcohol or use a drug first thing in the morning? Yes No

Review of Systems:

Please circle any complaints you currently have below:

General

Fatigue
Fever
Night sweats
Unplanned Weight loss

Respiratory/Lung

Shortness of breath
Wheezing
Cough

Mental Health

Anxiety or Panic
Depressed mood
Difficulty concentrating
Feeling of hopelessness

Urinary system

Frequent urination
Urgency to urinate
Urinary hesitancy
Urinary incontinence

Eyes and ENT

Blurry vision
Ringing in the ears
Seasonal Allergies
Sore throat

Gastrointestinal

Constipation
Diarrhea
Loss of stool
Heartburn

Neurological

Numbness / Tingling
Seizures
Frequent falls
Poor balance

Hematologic

Easy bleeding / bruising

Cardiovascular/Heart

Chest pain/pressure
Irregular heart beat
Swelling in feet

Musculoskeletal

Muscle aches
Back pain
Joint pain/stiffness
Muscle weakness

Skin

Rash
Sores / Ulcers

Past Medical Problems:

Please list any medical problems you have below (examples – high blood pressure, diabetes/sugar, etc).

Past Surgeries:

Please list any surgeries you have had below and the year they were performed.

Surgery type

Year

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Family History:

Please list any medical problems that your blood relatives have and their relation to you below.

Medications:

Please list all of the medications that you are currently taking including the dose and times per day.

Medication

Dose

Times Taken Per Day

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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Allergies:

Please list any medications that you are allergic to below.

Previous Diagnostic Studies:

Please list any xrays, MRIs, CAT Scans, EMGs, Nerve Conduction Studies below and when they were done.
