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Patient Questionnaire
Chronic Pain Version

Name: _____ DOB: _____ Today's Date: _____

Where is the pain? (for example: knees, back, head).

Does it seem to move anywhere else?

How and when did the pain begin?

What have you been told is causing your pain?

Tell us all you can about the pain:

What does it feel like (burning, tingling, shooting, sharp, aching)

What time of day does it occur?

What makes it start?

What makes it better?

What makes it worse?

What else?

Tell us all you know about previous evaluations of your pain.

❏ X- Rays Date: _____ ❏ MRI's Date(s): _____

❏ Other Diagnostic procedures: _____

Have you had any surgeries or procedures for treatment of your pain? Don't forget therapies and injections. If so, tell us what, where, and by whom.

❏ Injections
❏ Nerve Ablation
❏ Surgeries
❏ Physical Therapy
❏ Other: _____

Things you do to manage pain:
❏ Pain medication ❏ Heat ❏ Cold ❏ Massage ❏ Rest ❏ Other: _____

If you have any specific ideas of what should be done for your pain, please write them here.

Please list any other current medical problems:

Please list all of the medicines you are taking for any problems (use back if necessary):

Medicine	Treatment for	Start Date	Size (mg)	Times/Day

Please list any past mental health treatment:
❏ Psychiatrist ❏ Psychologist ❏ Counselor ❏ Medication from other doctor

Are you currently taking medicine or seeing a counselor for depression or anxiety or other mental health problem?

Have you ever attempted suicide? ❏ No ❏ Yes
Have you thought about wishing to die or commit suicide lately? ❏ No ❏ Yes
If you answered Yes to either of the questions above, please discuss in the interview.

Social History
Where did you grow up?

Who raised you? Biological / adoptive / foster / step parents /other_____, until what age? __

Describe your caretakers (type of work, personality, etc):

When growing up, how many brothers: _____ and sisters: _____

What type of relationship did you have with your parents?

What type of relationship did you have with your brothers/sisters?

How was your social adjustment growing up: ❑ Very good ❑ Good ❑ Average ❑ Not Good

Education:

Years of school ____ ❑ High school diploma ❑ Years of College____ ❑ Degrees_____
Grades: ❑ very good ❑ good ❑ average ❑ below average

Did you ever repeat a year? ❑ Yes ❑ No If so, what grade?._____
Did you ever receive Special Education Services? ❑ Yes ❑ No If so, in what grades?.____
Describe any discipline problems in school (suspensions, police intervention, etc):

Extracurricular Activities (sports, band, ROTC, etc) :

Social Activities (friends, dating, hobbies):

Substance Abuse:
Have you ever had problems with alcohol abuse?
Have you ever had problems with drug abuse?
Do you or others in your life think that you have a problem with alcohol or drugs now?

Do you ever drink alcohol?
If so, how often?
Do you ever use illegal drugs?
If so, what do you use and how often?

Legal Problems:
Describe any past criminal charges (i.e., reckless driving, DWI, theft, assault, etc.):

Legal Charge	*Date*	*Result (incarceration, parole, etc)*

Work:
Are you currently employed? ❑ Yes ❑ No
What is your occupation? _____ Length of time at this job _____.
If working, describe any times in the past 12 months that your illness has caused you to miss work:

Military History:
Please list branch of service, start and stop dates:

Marital/Relationship History:
How many times have you been married: _____
Current Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Unmarried partner
Describe your current relationship:

Number of children: _____ Ages: _____

Describe your current relationship with your children:

Who do you spend the most time with? (e.g., spouse, family, friends, etc):

Do you attend religious services?
If so, how often?

Is your religious faith important in your life?

Describe your current social interaction and your level of satisfaction with it:

How do others view you?

Assessment Checklist:

□ Signed release for referring doctor
□ Perceived Stress Scale
□ Dallas Pain Questionnaire
□ SOPA
□ CPCI
□ MMPI

DALLAS PAIN QUESTIONNAIRE

Name_____ Date_____ Date of Injury_____

This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0%-100% in each section.

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable? None Some All the time 0%(_____:_____:_____:_____:_____:_____)100%	How much does pain interfere with traveling in a car? None Some I can't travel 0%(_____:_____:_____:_____:_____:_____:_____)100%
How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc)? None(no pain) Some I can't get out of bed 0%(_____:_____:_____:_____:_____:_____)100%	How much does pain interfere with your job? None Some I can't work 0% (____:_____:_____:_____:_____:_____:____:____)100%
How much limitation do you notice in lifting? None Some I can't lift anything 0%(_____:_____:_____:_____:_____:_____)100%	How much control do you feel that you have over demands made on you? Total (no change) Some None 0%(_____:_____:_____:_____:_____:_____:_____)100%
Compared to how far you could walk before your injury or back trouble, how much does pain restrict walking now? The same Almost the same Very little I cannot walk 0%(_____:_____:_____:_____:_____:_____)100%	How much control do you feel you have over your emotions? Total (no change) Some None 0%(_____:_____:_____:_____:_____:_____:_____)100%
Back pain limits my sitting in a chair to: None Some I can't sit at all 0%(_____:_____:_____:_____:_____:_____)100%	How depressed have you been since the onset of pain? Not depressed significantly Overwhelmed by depression 0%(____:_____:_____:_____:_____:_____:____:____)100%
How much does pain interfere with your tolerance to stand for long periods? None(same as before) Some I can't stand 0%(_____:_____:_____:_____:_____:_____)100%	How much do you think your pain has changed your relationships with others? Not changed Drastically changed 0%(____:_____:_____:_____:_____:_____:____:____)100%
How much does pain interfere with your sleeping? None(same as before) Some I can't sleep at all 0%(_____:_____:_____:_____:_____:_____:____)100%	How much support do you need from others to help you during this onset of pain (taking over chores, meals, etc)? None needed All the time 0%(_____:_____:_____:_____:_____:_____:____)100%
How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc.)? None Some No activities 0%(____:____:_____:_____:_____:_____:____:____)100%	How much do you think others express irritation, frustration or anger toward you because of your pain? None Some All the time 0%(____:_____:_____:_____:_____:_____:____:____)100%
I-VIIx3=_____ VIII-Xx5=_____ XI-XIIIx5=_____ XIV-XVIx5=_____	

PSS

Name: _____ **Date:** _____

	The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.	0 =never 1 = almost never 2 = sometimes 3 = fairly often 4=very often				
1	In the last month, how often have you been upset because of something that happened unexpectedly?	⓪	①	②	③	④
2	In the last month, how often have you felt that you were unable to control the important things in your life?	⓪	①	②	③	④
3	In the last month, how often have you felt nervous and "stressed"?	⓪	①	②	③	④
4	In the last month, how often have you felt confident about your ability to handle your personal problems?	⓪	①	②	③	④
5	In the last month, how often have you felt that things were going your way?	⓪	①	②	③	④
6	In the last month, how often have you found that you could not cope with all the things that you had to do?	⓪	①	②	③	④
7	In the last month, how often have you been able to control irritations in your life?	⓪	①	②	③	④
8	In the last month, how often have you felt that you were on top of things?	⓪	①	②	③	④
9	In the last month, how often have you been angered because of things that were outside of your control?	⓪	①	②	③	④
10	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	⓪	①	②	③	④