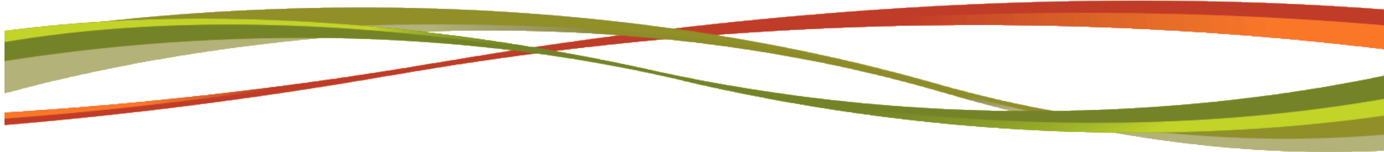

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Patient Questionnaire

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: _______________

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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