SANFORD M. SILVERMAN, MD, PA

Comprehensive Pain Medicine
Spinal Diagnostics & Therapeutics

PAIN MANAGEMENT QUESTIONNAIRE

We photograph all patients at the first visit. This is for our records only and is not distributed to anyone for research, publication or any other use.

DATE _____

Please read the following carefully and answer all the questions to the best of your ability. If does not apply, please indicate N/A. They will help us in better treating your pain. Thank you for your time and consideration.

NAME _____
LAST FIRST

AGE _____ HEIGHT _____ WEIGHT _____

Referring Physician(s _____

Other Physicians seen for this problem _____

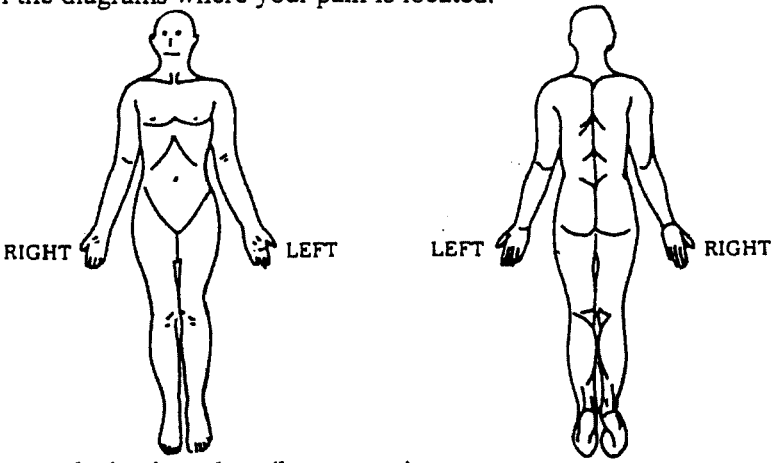
Allergies or adverse reactions to MEDICATIONS , IODINE OR CONTRAST , SHELLFISH_____

HOW LONG HAVE YOU HAD THIS PAIN? _____

How would you rate your pain on the scale below with **0** being no pain and **10** being the worst pain imaginable?

0 1 2 3 4 5 6 7 8 9 10
no pain **worst pain**

Please shade in the areas on the diagrams where your pain is located.



Please circle the appropriate words that best describe your pain.

ACHING	SHOOTING	DULL	CONSTANT
BURNING	TINGLING	TIGHT	RADIATING
CRAMPING	HOT	HEAVY	ANNOYING
NUMBING	COLD	INTENSE	SEVERE
STINGING	SORE	BRIEF	UNBEARABLE
STABBING	SHARP	TRANSIENT	EXCRUCIATING

1. Is your pain the result of an

	YES	NO
illness	☐	☐
accident	☐	☐

2. Are you presently involved in litigation or a law suit resulting from this accident? ☐ YES ☐ NO

If yes, what is the name of your attorney _____

3. Please indicate if the following **increases, decreases** or causes **no change** in your pain.

	INCREASES PAIN	DECREASES PAIN	NO CHANGE
LIQUOR	☐	☐	☐
STIMULANTS (coffee, etc.)	☐	☐	☐
EATING	☐	☐	☐
HEAT	☐	☐	☐
COLD	☐	☐	☐
DAMP	☐	☐	☐
WEATHER CHANGES	☐	☐	☐
PHYSICAL ACTIVITY	☐	☐	☐
MASSAGE	☐	☐	☐
PRESSURE	☐	☐	☐
WALKING	☐	☐	☐
SLEEP, REST	☐	☐	☐
LYING DOWN	☐	☐	☐
SITTING	☐	☐	☐
SEXUAL INTERCOURSE	☐	☐	☐
STANDING	☐	☐	☐
DISTRACTION (TV, etc.)	☐	☐	☐
URINATION	☐	☐	☐
BOWEL MOVEMENT	☐	☐	☐
TENSION	☐	☐	☐
BRIGHT LIGHTS	☐	☐	☐
LOUD NOISES	☐	☐	☐
FATIGUE	☐	☐	☐
SNEEZING, COUGHING	☐	☐	☐

4. Do you have difficulty sleeping? NO YES How many hours do you sleep at night? _____

5. Do you smoke? NO YES If so, how much and how long? _____

6. How much coffee or caffeinated beverages (tea, cola, etc.) do you drink daily? _____

7. How much beer or alcoholic beverages do you drink daily? _____

8. Do you drive a car with ☐ automatic transmission ☐ manual transmission

9. Do you sleep on ☐ water bed ☐ traditional mattress

10. What is your usual occupation? _____

11. Are you presently working? ☐ YES ☐ NO

12. Please indicate which diagnostic tests (procedures) you have had, in addition to where and when they were performed.

	YES	NO	DATE	LOCATION
X-RAY	☐	☐		
EMG	☐	☐		
MRI	☐	☐		
CT SCAN	☐	☐		
BONE SCAN	☐	☐		
MYELOGRAM	☐	☐		

13. Please check any of the following treatments you have had for this pain problem, including the dates and results.

TREATMENT	YES	PAIN RELIEF YES	NO	DATE DONE
NERVE BLOCKS, EPIDURAL STEROIDS	☐	☐	☐	
TENS UNIT	☐	☐	☐	
PHYSICAL THERAPY	☐	☐	☐	
TRACTION	☐	☐	☐	
ACUPUNCTURE	☐	☐	☐	
CHIROPRACTOR	☐	☐	☐	
PAIN CLINIC	☐	☐	☐	
PSYCHIATRIST, PSYCHOLOGIST	☐	☐	☐	
HYPNOSIS, BIOFEEDBACK	☐	☐	☐	
OTHER	☐	☐	☐	

14. Please list **ALL MEDICATIONS** (prescription & over-the-counter) you are currently taking. Please indicate the doctor who prescribed them.

MEDICATION / DOSE	REASON TAKEN	HOW OFTEN	DOCTOR

15. **ARE YOU CURRENTLY TAKING OR HAVE YOU RECENTLY TAKEN ASPIRIN, VITAMIN E, GINKO BILOBA? YES__ NO ___ IF YES, WHAT DOSE _____**

16. Have you ever taken or been given:

	YES	NO	WHEN? ANY PROBLEMS
Anti-coagulants (blood thinners - coumadin, heparin)	☐	☐	_____

Cortisone or steroids	❑	❑	_____
Local anesthetic (by doctor or dentist)	❑	❑	_____

17. Please list all surgeries you have had, when, and name of surgeon.

SURGERY	DATE	SURGEON
_____	_____	_____
_____	_____	_____
_____	_____	_____

18. Please check the appropriate space if you have had or presently have any of the following health problems.

❑ AIDS	❑ Epilepsy (Seizures)	❑ Kidney Problems
❑ Asthma	❑ Heart Disease	❑ Tuberculosis
❑ CVA (Stroke)	❑ Hepatitis	❑ Vascular Problems
❑ Diabetes	❑ Herpes Zoster (Shingles)	❑ Other: _____
❑ Emphysema	❑ Hypertension	❑ Other: _____

19. Please list any significant medical problems in your family, including parents and siblings.

20. Have you ever been treated for or had a history of addiction to alcohol or controlled or illicit substances?
❑ Yes ❑ No If yes, give details:

21. ADDITIONAL COMMENTS: Please add any comments which you feel would help in treating your pain.

Please answer the following questions using the following scales:
0 = NEVER 1 = RARELY 2 = SELDOM 3 = OFTEN 4 = VERY OFTEN

1. How often do you have mood swings? _____
2. How often have you felt the need for higher doses of medication to treat your pain? _____
3. How often have you felt impatient with your doctors? _____
4. How often have you felt that things are just too overwhelming that you cannot handle them? _____
5. How often is there tension in the home? _____
6. How often have you counted pain pills to see how many are remaining? _____
7. How often have you been concerned that people will judge you for taking pain medication? _____
8. How often do you feel bored? _____
9. How often have you taken more pain medication than you were supposed to? _____
10. How often have you worried about being left alone? _____
11. How often have you felt the craving for medication? _____
12. How often have others expressed concern over your use of medication? _____
13. How often have any of your close friends had a problem with alcohol or drugs? _____
14. How often have others told you that you have a bad temper? _____
15. How often have you felt consumed by the need to get pain medication? _____
16. How often have you run out of pain medication early? _____
17. How often have others kept you from getting what you deserve? _____
18. How often, in your lifetime, have you had legal problems or been arrested? _____
19. How often have you attended an AA or NA meeting? _____
20. How often have you been in an argument that was so out of control that someone got hurt? _____
21. How often have you been sexually abused? _____
22. How often have others suggested that you have a drug or alcohol problem? _____
23. How often have you had to borrow pain medications from your family or friends? _____
24. How often have you been treated for an alcohol or drug problem? _____

TOTAL SCORE: _____