Vital Total Health Medical Group

www.VitalTotalHealth.com (925) 388-9800

PAIN QUESTIONNAIRE

Name: ______________________________________ Date________________

Date of Birth: ______________ Age: _________

CHIEF COMPLAINTS: Rank problem areas, worse problem being #1, next #2, etc.

	Head & Face		Neck		Shoulders		Arms & Elbows
	Wrists		Hands		Upper/Mid Back		Low Back
	Hips		Knees		Ankles		Feet

___Pain, where: ____

___Numbness/Tingling, where:____

___Weakness, where: ____

How did it start? | In the last few months,...

	Injury or Accident, Date of Injury:_________		Symptoms are Persistent
	Illness or Condition, Onset Date: _______		Symptoms are Increasing
	Diagnosis:		Symptoms are Decreasing

____

____

Pain is: ___ Constant >90% ___ Frequent >70% ___ Intermittent 50% ___Occasional<30% of time

Pain intensity: *W*=worse pain level *L*=least pain level *A*=average pain level

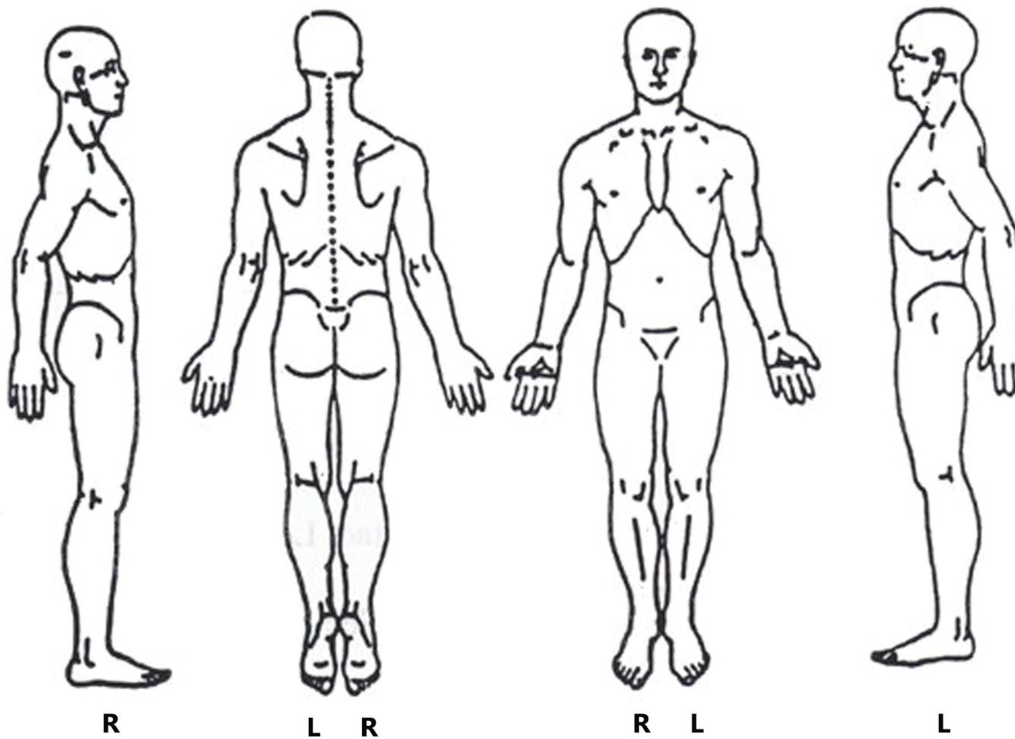
___ Severe, unable to move, 10 level

___ Moderately severe, prevents you from standing and walking after ten minutes, 7-9 level

___ Moderate, limits prolonged (30 min) activities such as sitting, standing, walking, 4-6 level

___ Slight, able to do activities, but the pain is made worse, 1-3 level

Please draw your pain:



XXX = Sharp or Stabbing Pain //////// = Achy Pain OOO = Numbness or Tingling

Pain is mainly in what areas?	
DoesPain travel to any areas?	
Are any areas tender to touch?	

WHAT MAKES PROBLEM WORSE: (Please **Circle**)

Sitting over ___ min	Standing over ___ min	Walking ___ min	Lying down	Coughing
Lifting over ___ lbs	Carrying over ___ lbs	Bending	Reaching	

WHAT MAKES PROBLEM BETTER: (Please **Circle**)

Reclining	Sitting	Lying down	Walking with cane with walker	Exercise

PRIOR WORK UP FOR PRESENTING PROBLEM: Have you had--

Yes	No	STUDY	Year	Findings
		Labs		
		X-rays		
		MRI		
		EMG		

PRIOR TREATMENT FOR PRESENT PROBLEM: Have you had--

Yes	No	TREATMENT	Date MM/YYYY	Did it help?
		Physical Therapy		
		Exercise		
		Biofeedback		
		Chiropractic		
		TNS or TENS		
		Acupuncture		
		Psychotherapy		
		Injection-Trigger Point		
		Injection-Joint		
		Injection-Epidural/Facet		
		Injection-PRP/Stem cells		
		Surgery		
		Stimulator		
		Medications		

Prior Health Care Providers, City:

Primary Care Physician	
Pain Management Physician	
Medical Specialist/Surgeon	
Chiropractor	
Acupuncturist / Physical Therapist	

OTHER PAST INJURIES:

Date	Injury

PAST MEDICAL HISTORY: Medical problems being treated *now* or in the *past*.

	Seizures		Stroke		Glaucoma		Thyroid Disease
	Diabetes		Hypertension		High Cholesterol		Heart Disease
	Arrhythmia		COPD		Asthma		Gastritis PUD GERD
	Pancreatitis		Hepatitis		Kidney Disease		Genital: Prostate
	Genital: Gyn		Arthritis		Chronic Infection		Cancer
	Addiction		Depression		Anxiety		Stress
	ADHD						

PAST SURGERIES:

mm/yyyy	Operation	Did it help?

FAMILY HISTORY: (Does any family members suffer from?)

Yes	No	Disease	Please **circle**
		Thyroid Problems	Mother Father Siblings Children
		Diabetes	Mother Father Siblings Children
		High Blood Pressure	Mother Father Siblings Children
		Heart Disease	Mother Father Siblings Children
		Stroke	Mother Father Siblings Children
		Arthritis	Mother Father Siblings Children
		Autoimmune Disease	Mother Father Siblings Children
		Cancer	Mother Father Siblings Children
		Addiction	Mother Father Siblings Children
		Depression Psych	Mother Father Siblings Children

SOCIAL HISTORY: (Please **Circle** all that apply)

Never smoked	Quit smoking	Smoker	Recreational drugs
No Alcohol	Quit Alcohol	Social Alcohol	Daily Alcohol
Single	Married	Divorced	Have Children
High School Degree	Some College	College Graduate	Post-graduate degree
Employed	Retired	Unemployed	On State Disability
On Work Comp Disability- - Temp-Permanent		On Social Security Disability for	

ALLERGIES TO DRUGS OR ANESTHESIA:

List drug, or write None	Reaction (Rash, swelling, shortness of breath)

PRESENT MEDICATIONS: Please list presently prescribed medications

Drug	mg	How often a day?	Prescribing Physician	For what condition

What medications have you tried in the past for pain?

Drug	Strength	Did it help? Yes/No	Any side-effects?

REVIEW OF SYSTEMS: Do you have? ---

Yes	No	**CIRCLE** ANY PROBLEMS
		Fevers. Chills. Excessive sweating. Fatigue.
		Unexplained weight loss or gain. Poor appetite. Hgt___ Wgt___
		Sleep less than 6 hrs. Wake up at night more than 3 times.
		Headaches. Migraines. Seizures.
		Vision blurred. Double vision. Excessive tearing. Blind spot. Dry eyes.
		Difficulty hearing. Ringing in the ears. Dizziness.
		Nasal congestion. Sinus Congestion. Nose bleeds. Unable to smell or taste.
		Broken/missing teeth. Sores. Gum bleeding Pain eating. Jaw Pain/popping.
		Sore throat. Difficulty in swallowing Hoarseness. Swollen glands.
		Chest pain. Rapid or irregular heart beats. Feet swelling.
		Shortness of breath walking. Wheezing. Difficulty in breathing. Coughing.
		Heartburn. Nausea. Vomiting. Gas. Abdominal pain. Yellow jaundice.
		Diarrhea. Constipation. Bright red blood in stool. Dark stool.
		Frequent urination. Burning. Urgency. Weak urine flow. Wake up to urinate
		Weakness. Fatigue. Joint pain. Muscle pain. Problems with Balance.
		Skin rashes. Moles. Redness or Infection. Easing Bruising. Track marks.
		Numbness. Tingling. Seizures. Forgetful.
		Repeatedly or overly worried. Rapid thoughts. Trouble falling asleep. Snoring.
		Feelings of sadness or depression. Feelings of hopelessness. Suicidal thoughts

Signed: ___________________________________ Date: ____________________