Specialized Medicine

BOLTZ

PAIN AND WELLNESS CENTER

PAIN LEVEL QUESTIONNAIRE

Patient Name _____

Date of Birth _____ Today's Date _____

Primary Care Physician _____

Referring Physician _____

Reason for visit _____

Please check all that apply:

Location of Pain
☐ Low Back Pain ☐ Mid Back Pain ☐ Neck Pain ☐ Shoulder Pain ☐ Other _____
☐ Headaches ☐ Leg Pain ☐ Hip Pain ☐ Arm Pain
☐ Foot Pain ☐ Knee Pain ☐ Hand Pain ☐ Muscle Weakness

When did your symptoms appear? (Month and Year) _____

Check the number that best describes your pain. 0 = no pain 10 = worst pain ever

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does your job involve? Heavy lifting Prolonged sitting Computer work Excessive Bending Other _____

Which of the following increases your pain?

☐ Sitting ☐ Standing ☐ Walking ☐ Sleeping ☐ Sex ☐ Socializing ☐ Eating ☐ Exercising ☐ Other _____

Women only: Are you currently pregnant? ☐ Yes ☐ No

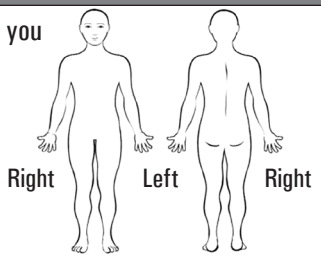
Have you had an
MRI? ☐ Yes ☐ No If so, When? _____
Bone Scan? ☐ Yes ☐ No Location ? _____
X-Ray ☐ Yes ☐ No Part Of Body _____
CT Scan ☐ Yes ☐ No

Check the following that describes your pain

☐ Sharp ☐ Dull ☐ Tingling ☐ Numbness ☐ Throbbing ☐ Aching
☐ Cramps ☐ Burning ☐ Swelling ☐ Stiffness ☐ Other _____

Is your pain...
☐ constant ☐ come and go ☐ worse at night ☐ worse with sitting ☐ worse when standing ☐ worse when walking

Shade on the diagram where you are experiencing pain



Complete Review of Systems: Check all that apply

General
☐ Chills ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Sleep Disturbance

Integumentary
☐ New Lesions ☐ Rashes ☐ Bruising ☐ Skin Changes

E.N.T
☐ Headache ☐ Visual Disturbances ☐ Visual Loss ☐ Deafness ☐ Decreased Hearing ☐ Seasonal Allergies ☐ Sinus Problems

Endocrine
☐ Insulin Dependent ☐ Non-Insulin Dependent ☐ Thyroid Problems

Neurological
☐ Difficulty Speaking ☐ Numbness in Limbs ☐ Lightheaded ☐ Spinning Sensation

Genitourinary
☐ Incontinence in Urine ☐ Blood in Urine ☐ Change in Bladder Habits ☐ Impotence

Psychiatric
☐ Anxiety ☐ Depression ☐ Bi-Polar ☐ Schizophrenia ☐ Suicidal Thoughts ☐ Substance Abuse ☐ Rehab

Respiratory
☐ Shortness of Breath ☐ Cough ☐ Oxygen Dependent ☐ Wheezing

Gastrointestinal
☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Ulcers

Social/Vocational History

☐ Married/lives with spouse ☐ Never Married ☐ Divorced/ Seperated ☐ Widow/widower ☐ Lives w/ significant other
☐ Lives alone ☐ Primary caretaker of invalid family member ☐ Other _____

Do you have any children? ☐ No ☐ Yes How many? _____

Occupation: ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ Employed By Whom _____

Do you smoke? ☐ Yes ☐ No Packs a day _____ Years _____ Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ None

Do you drink caffeine? ☐ Tea ☐ Coffee ☐ Soda ☐ Energy Drinks ☐ Other _____