VAUGHN SPINE and ORTHOPEDICS PLLC

Pain Assessment Questionnaire

Name:_____ DOB:_____ Date:_____

1. **What body part are you being seen for today?** _____

2. **Is this injury related?** ❑Yes❑No **Is this a WC Injury?** ❑Yes ❑No **Date of Injury?**_____

3. **Rate your pain: 0 = No pain 10 = Extreme pain (Please mark one box for each row)**

A. **Current:**	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
B. **Maximum:**	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
C. **Minimum:**	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10
D. **Average:**	❑0	❑1	❑2	❑3	❑4	❑5	❑6	❑7	❑8	❑9	❑10

4. **How did this start?** ❑Gradual ❑Suddenly ❑Unknown ❑After an accident

5. **When did this start/How long ago?(put a #)** _____Days _____Weeks _____Months _____Year(s)

6. **Describe your pain**: ❑Constant ❑Dull ❑Intermittent ❑Mild ❑Moderate ❑Severe ❑Sharp

7. **What makes the pain worse/aggravates it?** (May check more than one)

❑Any Movement	❑Lifting	❑Prolonged Sitting
❑Bending	❑Driving	❑Prolonged Standing
❑Twisting	❑Getting in/out of cars or chairs	❑Prolonged Walking
❑Stooping	❑Repetitive Motion	❑ Use of arm/hand/wrist
❑Squatting	❑Overhead Work	❑Use of foot/ankle/leg

❑**Turning head**: ❑ Right ❑ Left ❑Up ❑ Down

8. **What relieves the pain?** (May check more than one)

❑ Brace	❑Cold	❑ Heat	❑Ibuprofen	❑ Lying down ❑Pain medicine
❑ Rest	❑Sitting	❑ Nothing	❑ Other, please describe _____	

9. **What treatments have you already tried?** ❑Anti-inflammatory ❑Imaging Studies ❑Injections ❑ Pain Medicine ❑ Physical Therapy ❑Surgery ❑PCP -Date:_____ ❑E.R. Date:_____

10. **Did any of these treatments work?** ❑Yes ❑No If so, What?_____

11. **Have you been dismissed from an Inpatient Facility within the last 30 days (Hospital, Rehab, Nursing Facility)?** ❑Yes ❑No *__If Yes__, please list any Rx on Meds List & let us know if you finished or if you are still taking medication*

Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your: 0=Does Not Interfere 10=Completely Interferes

A. General Activity

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

B. Mood

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

C. Walking Ability

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

D. Normal Work (includes both work outside the home & housework)

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

E. Relations with Other People/ Attention Span

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

F. Sleep

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

G. Enjoyment of Life

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

12. **Associated Symptoms-Show by marking/drawing on the figures below where you have been having most of your:** Decreased Range of Motion^^^^ Swelling++++ Aching or painXXXX Cramping**** Numbness or tingling OOOO Pins and needles …. Burning //// Draw arrows ⇕ where pain radiates/shoots