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)

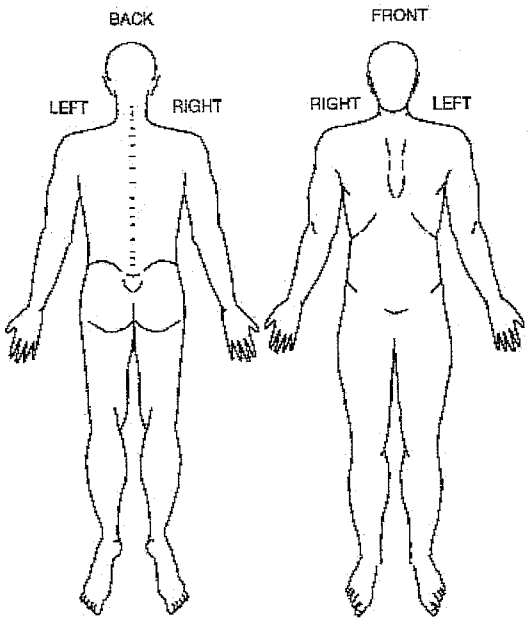
| | | | | | |
|---|---|---|---|---|---|
| ❑ Brace | ❑Cold | ❑ Heat | ❑Ibuprofen | ❑ Lying down | ❑Pain medicine |
| ❑ Rest | ❑Sitting | ❑ Nothing | ❑ Other, please describe _____ | | |

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 *<u>If Yes</u>, please list any Rx on Meds List & let us know if you finished or if you are still taking medication*

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




13. In general, would you say your health is: ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor
14. Does your health now limit your General Activity such as walking? ❒Yes ❒No
15. Does it now limit your Moderate Activity such as moving a table, playing golf, etc.? ❒Yes ❒No
16. Does it limit you climbing stairs? ❒Yes ❒No
17. Over the past 4 weeks have you had problems with your work or regular activities due to your physical health? ❒Yes ❒No
18. Over the past 4 weeks have you had problems with your work or regular activities due to any emotional problems (such as depression or anxiety)? ❒Yes ❒No
19. Over the past 4 weeks has pain interfered with your work or regular activities? ❒Yes ❒No
20. Over the past 4 weeks has pain interfered with your sleep? ❒Yes ❒No

****Please answer the following questions by marking the answer that comes closest to the way you have felt over the last 4 weeks****

| | All the Time | Most the time | Some of the time | A little of time | None of the time |
|---|---|---|---|---|---|
| 21. Have you felt calm & peaceful? | ❒ | ❒ | ❒ | ❒ | ❒ |
| 22. Do you have a lot of energy? | ❒ | ❒ | ❒ | ❒ | ❒ |
| 23. Have you felt downhearted or blue? | ❒ | ❒ | ❒ | ❒ | ❒ |
| 24. How much has your problem | | | | | |
| 25. interfered with your social activities such as visiting friends or relatives, etc.? | ❒ | ❒ | ❒ | ❒ | ❒ |