HEALTHYLIVING PRIMARY CARE
Pain Questionnaire

Name: ________________________________________________________  Today’s Date: ______________
Date of Birth: __________________________  ____ New  ____ Follow Up

Please fill out this form before your appointment, so it will be ready to be reviewed at your appointment to prevent delay:

1. Describe your pain? **Circle** the words that best describe it. If this is a follow up, if your pain getting worse, better or the same?
   - Aching
   - Burning
   - Constant
   - Cramping
   - Deep
   - Dull
   - Exhausting
   - Gnawing
   - Intermittent
   - Miserable
   - Nagging
   - Numb
   - Penetrating
   - Pricking
   - Radiating
   - Sharp
   - Shooting
   - Squeezing
   - Stabbing
   - Throbbing
   - Tiring
   - Unbearable

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

2. **Circle** all the things that makes your pain worse.
   - sitting
   - standing
   - rest
   - heat
   - cold
   - walking
   - exercise
   - sex
   - touch
   - other _____

3. **Circle** all the things that makes your pain better.
   - sitting
   - standing
   - rest
   - heat
   - cold
   - walking
   - exercise
   - sex
   - touch
   - other _____

4. On the diagram, **shade the areas** where you feel pain. Put an **X** on the area that hurts the most.

5. How long have you had this pain?
   ________________________________________
   ________________________________________
   ________________________________________

6. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  No  Yes, what kind? _____

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
7. Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours.

   0 1 2 3 4 5 6 7 8 9 10
   No pain as bad as pain you can imagine

8. Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the last 24 hours.

   0 1 2 3 4 5 6 7 8 9 10
   No pain as bad as pain you can imagine

9. Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

   0 1 2 3 4 5 6 7 8 9 10
   No pain as bad as pain you can imagine

10. Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

    0 1 2 3 4 5 6 7 8 9 10
    No pain as bad as pain you can imagine

11. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much **RELIEF** you have received.

    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
    No relief Complete Relief

12. **Circle** the one number that describes how, during the past 24 hours, pain has interfered with your:

    a. **General Activity**
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes

    b. **Mood**
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes

    c. **Walking Ability**
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes

    d. **Normal work** (includes both work outside the home and housework)
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes

    e. **Relations with other people**
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes

    f. **Sleep**
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes

    g. **Enjoyment of Life**
       0 1 2 3 4 5 6 7 8 9 10
       Does not interfere Completely interferes
Current Opioid Treatment (if applicable)

1. What is your current treatment regimen? Please be specific:
   ____________________________________________________________________________________
   ____________________________________________________________________________________

2. When was the last time you took your narcotics? ________________________________

3. What percent relief does your narcotics provide? ____________%

4. Do you have any side effect from the medication?

<table>
<thead>
<tr>
<th>Appetite change</th>
<th>Dry mouth</th>
<th>Menstrual changes</th>
<th>Tooth decay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Erectile problem</td>
<td>Nausea</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Confusion</td>
<td>Itching</td>
<td>Problems urinating</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Lightheadedness</td>
<td>Sleepiness</td>
<td></td>
</tr>
</tbody>
</table>

5. Are you more functional from using the narcotics? (circle)
   No   Yes   If so, how? _____________________________________________________________

6. Do you feel that your mood has improved from narcotic therapy? (circle)
   No   Yes   If so, how? _____________________________________________________________

7. Has your quality of life improved? (circle)
   No   Yes   If so, how? _____________________________________________________________

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**Medical Assistant Check List**

Did patient bring pill bottle?    Yes    No
Pharmacy Listed on bottle _________
Opioid Count: ________
Consistent   Yes   No
If No, how? _______________________________________________________________________

Urine Drug Testing if applicable:

_________________________________  __________________________________

Medical Assistant / Date                  Provider / Date