# *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 | Exhausting | Penetrating | Stabbing |
| Burning | Gnawing | Pricking | Throbbing |
| Constant | Intermittent | Radiating | Tiring |
| Cramping | Miserable | Sharp | Unbearable |
| Deep | Nagging | Shooting | |
| Dull | Numb | Squeezing | |

_____
_____
_____
_____

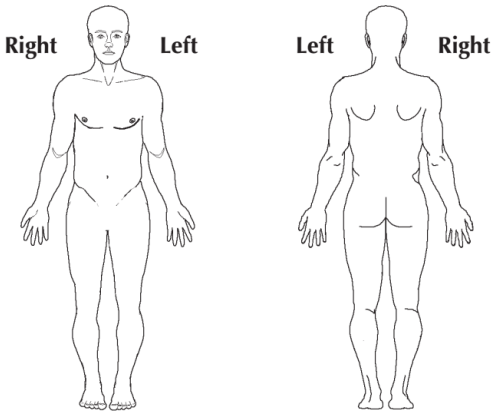
2. ***Circle*** all the things that makes your pain **worse**.

   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?

| | | | |
|---|---|---|---|
| Appetite change | Dry mouth | Menstrual changes | Tooth decay |
| Constipation | Erectile problem | Nausea | Vomiting |
| Confusion | Itching | Problems urinating | |
| Dizziness | Lightheadedness | Sleepiness | |

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? _____

**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