Pain Questionnaire

KAISER PERMANENTE®

I was referred by Dr. or P.A. _____

My pain started (how many?)_____weeks,_____months, or_____years ago.

My pain has been worse for the last (how many?)___weeks,_____months, or_years ago.

If you have been treated by a Kaiser Permanente Anesthesiologist before today, please describe your pain since your last visit. My pain has been *(please circle the response):*
*unchanged *gradually improving *rapidly improving *gradually worsening
*rapidly worsening *completely resolved *intermittent
over the last (how many?) _____weeks_____months, or_____years.

My pain score (where 0 is the least and 10 the worst pain): Today_____ Worst pain_____Least pain_____

My pain feels like *(please circle the correct response/s):* *aching *burning *numbing *sharp *tearing
*stabbing *throbbing *dull *radiating *other_____

The following activity/motion aggravates my pain: *(please circle the correct response/s):*
*bending *walking *lying *crouching *sitting *lifting *reaching *twisting *standing
*other:_____

The following relieves my pain *(please circle the correct response/s):* *NSAIDS *acetaminophen *rest
*heat *ice *topical ointments *muscle relaxants *narcotics *standing *lying
*pressure *physical therapy *nothing *other:_____

My pain is located *(please circle the correct response/s):*
In my: *low back *mid back *upper back **or** *neck, on the *right *left or *midline
I also have pain in my: *buttock *hip *thigh *groin *knee *calf *ankle
*foot *shoulder *upper arm *lower arm *hand, on the *right or *left

Please circle the correct response:
I *have or *have not had similar symptoms in the past.
I *have or *have not had spinal surgery in the past.
Type of surgery: _____ Surgery date:_____

I take blood thinners such as *(circle medication/s):*
Coumadin (waifarin), heparin, Plavix (clopidogrel), Aggreno (aspirin/dipyridamole),
Lovenox (enoxaparin), Ticlid (ticlodipine), Other_____

Do you have any of the following symptoms or illnesses? *(Please circle your answer)*

Persistent fevers	Yes	No	Allergy to latex	Yes	No
Major muscle weakness	Yes	No	Diabetes	Yes	No
Bladder or bowel dysfunction	Yes	No	HIV/AIDs	Yes	No
Unrelenting pain at night	Yes	No	Hepatitis history	Yes	No
History of major trauma	Yes	No	Bleeding disorders	Yes	No
Allergy to iodine	Yes	No			