

Professional Pain Medicine

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**New Patient
Pain Questionnaire**

Name: _____

Date of Birth: _____

Phone number—home(____) _____ business(____) _____

Referring Physician: _____

Is your pain the result of an accident? If so, please give dates and describe: _____

When and how did your pain symptoms start? _____

Is there anything that makes your symptoms better (heat, cold, rest, medications)? _____

Is there anything that makes your symptoms worse (walking, standing, lifting)? _____

Which of your daily activities are you not able to do because of your back symptoms?

What time of the day is your pain the worst?

- When you first wake up in the morning?
- Later in the morning?
- Afternoon?
- Evening?
- Bedtime?
- While trying to sleep
- None of the above—it hurts all of the time

Describe your pain:

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tight |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electrical |

Have you noticed any problem with your legs (weakness, dragging a foot, limping)? _____

Around the time your symptoms began, did you have a fever or symptoms of pain or burning when urinating? _____

Which doctors have you seen for your pain? When did you see them? What did they do?

Doctors name	Month/Year seen	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and studies have been done? (example: MRI, CT scan, X-rays)

Tests

Month/Year done

Results

Your Medical History:

Have you had a problem with your back/neck in the past? If so, when?

Have you ever had surgery on your back or neck? If so, what levels and when?

Have you ever had previous back or neck injections? If so, when, how many?

What medical illnesses have you had (for example, cancer, arthritis, or diseases of the immune system)?

Which medicines do you take regularly:

Which medications you have tried for your pain?: Celebrex Vioxx Advil
 Vicodin Others _____

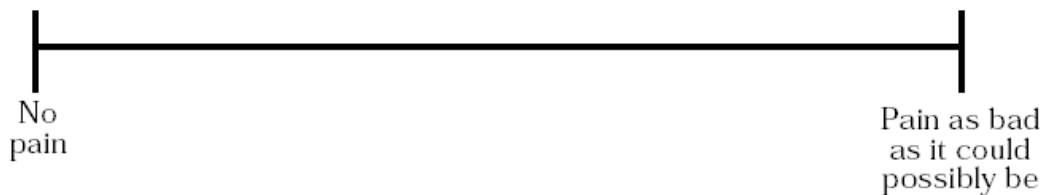
Do you have any allergies to medications? If so, which?

Have you ever used intravenous (IV) drugs? If so, which and when? _____

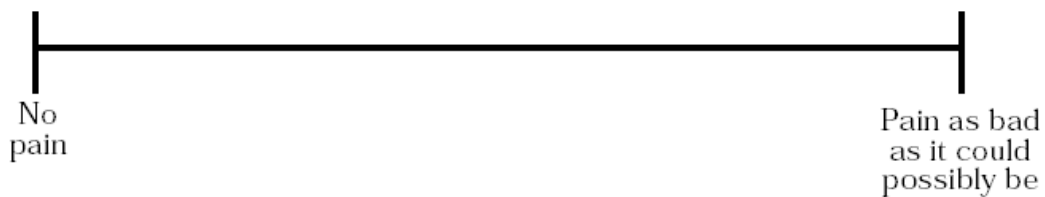
Have you recently lost weight without trying? _____

What are your expectations of pain therapy? What activities would you like to return to that you are currently unable to participate in? _____

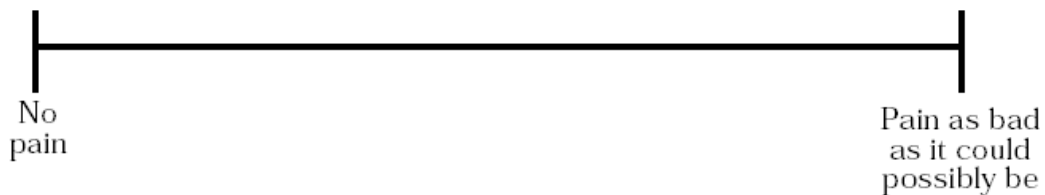
Rate your current pain: Place an **X** on the line that corresponds to your pain



Rate your pain at it's worst: Place an **X** on the line that corresponds to your pain:



Rate your pain at it's least: Place an **X** on the line that corresponds to your pain



Please diagram your pain:
xxx-----Pain
ooo----Numbness or Tingling

