

Professional Pain Medicine

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**Returning Patient
Pain Questionnaire**

Name_____

Date of Birth_____

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

In general, have you been feeling better or worse since our last visit?_____

Has your usage of pain medicine changed since our last visit? If so, how?_____

Are you sleeping better at night since our last visit? Yes No

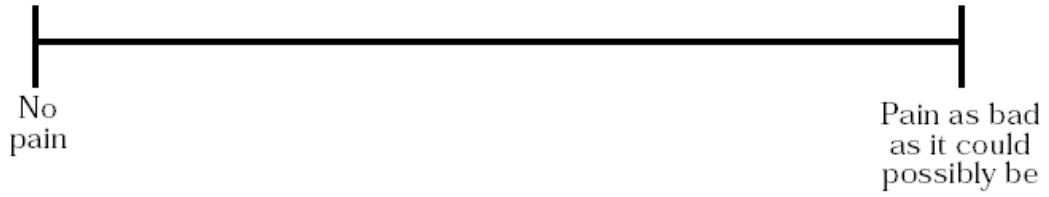
Are you walking better since our last visit? Yes No

Has any numbness/ tingling decreased since our last visit? Yes No

Has your pain decreased since our last visit? Yes No

Do you have any new pain symptoms since our last visit? Yes No
If yes, please describe:_____

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



Please diagram your current pain:

xxx----Pain

ooo----Numbness or Tingling

