UNIVERSITY of [redacted]

Pain Treatment Center

Patient Questionnaire

Patient Identification Sticker

PLEASE FILL OUT AND BRING WITH YOU TO YOUR FIRST APPOINTMENT. BE SURE TO INCLUDE A LIST ALL YOUR MEDICATIONS AND ANY X-RAY/MRI IMAGING RELATED TO YOUR PAIN.

When did your pain begin:

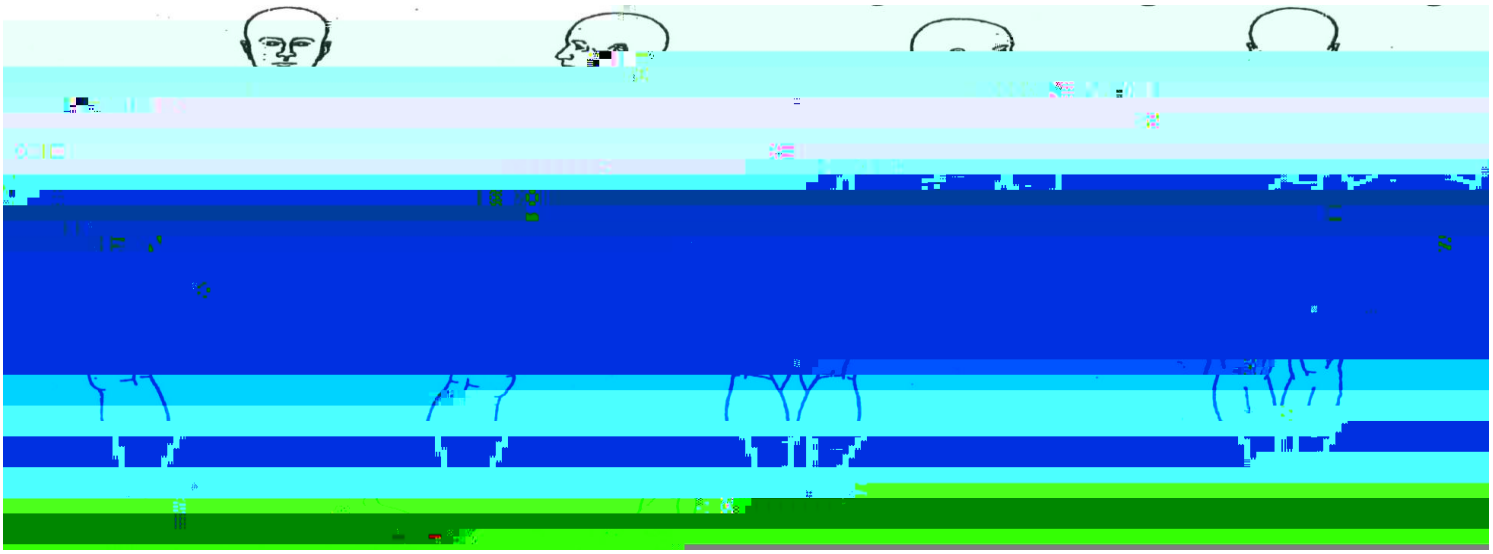
Describe how your pain started (ex. Accident, lifting, surgery, following an illness):

The Pain (Please Check One):	
☐	
☐	
☐	
☐	

Since the beginning of the present problem, has the intensity of the pain (Please Check One)	
☐	
☐	
☐	
☐	
☐	

Please indicate on a scale of 1 - 10 intensity of your pain. 0 being NO PAIN, 10 being VERY SEVERE PAIN	

On the picture below - mark the area of your pain



Yes No

Yes No

Treatments

UNIVERSITY of [redacted]

Pain Treatment Center

Patient Questionnaire

Patient Identification Sticker

Medications

Current Pain Medications				

Current Other Medications (Include over-the-counter medications)				

Allergies

Medications (List with Reaction)
Latex Allergies (If yes describe reaction) - Y N
Contrast Allergies (If yes describe reaction) - Y N

Patient Questionnaire

Patient Identification Sticker

Pain Treatment Center

No	Past Medical History
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	

Please List Prior Surgeries

No	Family History
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	

Personal History

Pain Treatment Center

Yes	No	Work History

Yes	No	Social History