1) Please circle on the diagram below the areas where you feel pain.
2) If your pain moves, please draw arrows on the diagram to indicate this movement.
3) If you feel numbness or tingling, draw an “x” on the diagram to indicate areas you feel it.

4) Using the scale below, please indicate how bad your pain is:
   a. At its worst (0-10) ________
   b. At its least (0-10) ________
   c. As it is right now (0-10) ________
If your pain is due to an injury, what was the date of injury? ____________________________

5) What started your pain or what were you doing when your pain started? ________________

Please circle one:

7) Do you feel you have weakness? Yes No
8) Do you have back/neck muscle spasms? Yes No
9) Do you have arm/leg cramps? Yes No
10) Do you have headaches along with the other pain? Yes No
11) How many years have you been having pain?
   a. less than one year
   b. one to 10 years
   c. more than 10 years
12) When did your most recent episode of pain start?
   a. less than a month ago
   b. within the last one to three months
   c. more than three months ago
13) Which best describes the duration of your pain?
   a. constant
   b. intermittent
14) During which part of the day is your pain the worst?
   a. Morning
   b. afternoon
   c. evening
   d. night

Please circle ALL that apply:

15) How would you describe your pain?
   a. aching
   b. throbbing
   c. shooting
   d. stabbing
   e. burning
   f. sharp
   g. dull
   h. (other)__________________
16) What makes your pain better?
   a. standing
   b. sitting
   c. walking
   d. lying
   e. heat
   f. ice
   g. stretching
   h. medications
   i. nothing
17) What makes your pain worse?
   a. standing
   b. sitting/driving
   c. walking
   d. lying
   e. coughing/sneezing/straining
   f. other

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18) Have you tried?
a. physical therapy
d. epidural/cortisone injections
b. acupuncture
e. surgery
c. chiropractic care
f. none of the above

19) For the body part in pain, have you had?
a. X-rays
d. bone scan
b. CT scans
e. none of the above
c. MRI

20) What **medical conditions** do you have?
a. heart disease
i. kidney disease
b. high blood pressure
j. chronic/active infection
c. diabetes
k. cancer
d. stomach ulcers
l. depression
e. stroke
m. bi-polar disorder
f. arthritis
n. other
g. glaucoma

21) What **surgeries** have you had?
a. neck
f. foot
b. back
g. carpal tunnel
c. hip
h. other
d. shoulder
i. none
e. knee

22) What is your **family history** of medical conditions?
a. arthritis
f. high blood pressure
b. heart disease
g. other
c. stroke

Please circle or fill in the blank:
23) If applicable, can you list the cause of death of any of your family members?  
(i.e., grandparents, parents, siblings, children)

24) Are you?  married      single      divorced     separated       widowed

25) If you are a parent, what are the ages of your children?  

26) Do you?  smoke      drink alcohol      use marijuana/illicit drugs      none
27) What is your occupation/trade? ____________________________________________

27) What is your current work status? full-time on disability part-time retired not working

28) If any, what are your work restrictions? _______________________________________

29) If you are not working, what was the date you last worked: _______________________

30) Please list your drug allergies and what type of reaction you had:

_____________________________________________________________________________

_____________________________________________________________________________

31) Please list your medications and doses including as needed pain medications:

_____________________________________________________________________________

_____________________________________________________________________________

32) Do you have any of the following symptoms?
   a. stool incontinence/retention
   b. urine incontinence/retention
   c. numbness/tingling in groin or genitals
   d. chest pain
   e. shortness of breath
   f. skin lesions/cancers
   g. blurry vision
   h. wear eyeglasses/contact lens
   i. depression
   j. swelling of arms/legs/hands/feet
   k. unknown fatigue/weight gain
   l. ringing in ears
   m. nasal drip
   n. none of the above

33) What is your height (for example, 5'6")? __________

34) What is your weight (for example, 150 pounds)? ______

35) Which hand is your dominant one: right left