PAIN QUESTIONNAIRE

NAME OF PATIENT/CLAIMANT: **SOCIAL SECURITY NO:**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

1. When did you first have pain?

2. When did the pain first begin to affect your activities?

3. Are you now receiving medical treatment for your pain? If so, please note the following information about your medical physician or health care provider:
Name:
Name of Clinic or Facility:
Address:
City:
Zip:
Phone No.

4. Have you ever had special tests to evaluate your pain? If so, please indicate the following:
Where tests were done:
By Which Medical Facility or Physician:
Address:
City, State, ZIP:

5. Where do you feel the pain? Please describe exactly where the pain is located.

6. Does it spread/radiate to other places in your body: If so, describe where.

7. What does the pain feel like? Is it dull, an ache, throbing, stabbing, sharp, burning, etc.?

Is your Pain Chronic or so bad that it affects your life, work or relationships to other people? ☐YES ☐NO

8. How often do you experience the pain on the average per day, week or month?

9. What activities bring on the pain?

10. How long does the pain last when you experience it?

11. Since you first felt the pain, has it changed in how it feels or the part of the body where you feel it? Is your pain staying about the same, getting worse or getting better? Please describe.

12. Are you taking any medication for the pain? If so, please give the following information:
Name of medication Purpose DosageTime(s) per day you take it

13. Does the medication relieve or reduce the pain?

14. How soon does it relieve the pain and for how long?

15. When did you first start taking the medication?

16. Does it have any adverse side effects? If so, what are they?

17. In the past, have you taken other medication for the pain? If yes, why did you stop or change?

18. What other things do you do or use to relieve the pain? Do you wear any devices like a corset or back brace, use a cane, use a TENS unit, etc.? Please describe.

19. What are your current daily activities? Weekly activities? Please describe things like walking, shopping, household chores, driving, socializing, hobbies, etc.

20. Has the pain affected your activities? If so, please describe what activities have been affected.

21. Who else can tell us about your pain and how it affects your activities? Please give the following information:
Name:
Address:
City: Zip:
Phone:

22. How long or how far can you perform the following tasks without difficulty

	How Far/ How long?	Difficulty you would experience?
Walk?		
Sit?		
Stand?		
Lift?		
Bend?		
Squat?		
Climb?		
Kneel?		
Twist?		
Crawl:		
Reach with feet?		
Reach with hands?		
Driving/riding in vehicle?		

23. Have your relationships with other people been affected by your pain? If so, explain if you have:
☐Irritability ☐Withdrawal ☐Stress ☐Depression ☐Concentration/Memory Problems
☐Problems with Work Pace/Persistence

22. Is there any other information you would like to tell us about your pain? If so, please describe.

Signature _____ Date _____
Printed Name:

PATIENT/CLAIMANT'S WORK BACKGROUND

NAME OF PATIENT/CLAIMANT: **SOCIAL SECURITY NUMBER:**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

To be completed by the claimant - Please prepare facts carefully before entering any information. Wrong information can be embarrassing. Start at the top with your most recent job first, followed by next most recent job (and so on), and list all jobs performed within the past 15 years. Weight lifted information is to be considered a *single* object weight and not weights added:

Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
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(If additional space is needed, use back of form)

SIGNATURE	DATE

PRESCRIPTION MEDICATIONS LIST

NAME OF PATIENT/CLAIMANT: **SOCIAL SECURITY NO:**

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Please list all PRESCRIPTION Medications you are CURRENTLY taking plus the information asked. Please be accurate and give full information requested to include dosage:

Name of Medication and Dosage	Date first Prescribed	Daily Amount Taken	Reason for Medication	Physician Name	Adverse Effects such as stomach upset, dizzy, etc.

*Please list below any **NON-PRESCRIPTION** medications you are taking, how often you take them, and the reason for taking them*

(If additional space is needed, use back of form)

SIGNATURE	DATE