

PAIN CLINIC

Pre-Appointment Questionnaire

NAME _____

DATE OF BIRTH _____

1. WHERE IS YOUR PAIN?

Mark on a body diagram if provided.

- | | | |
|------------------------------------|---|--|
| ☐ Head | ☐ Right Shoulder | ☐ Left Shoulder |
| ☐ Right Arm | ☐ Left Arm | ☐ Upper Back |
| ☐ Mid Back | ☐ Low Back Pain | ☐ Right Leg |
| ☐ Left Leg | ☐ Other: _____ | |

2. HOW LONG HAVE YOU HAD THIS PAIN?

- ☐ Less than 3 months
 ☐ 3–6 months
 ☐ More than 6 months

3. PAIN INTENSITY

Circle the number that best describes your pain.

0 = no pain

10 = worst pain imaginable

Right now

0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10

At its WORST in the past week

At its LEAST in the past week

On AVERAGE

4. HOW PAIN AFFECTS YOUR DAILY LIFE

Circle the number that best describes how pain has interfered with each area in the past week.

0 = does not interfere

10 = completely interferes

General daily activities

Walking or moving around

Work or household tasks

Sleep

Mood

Relationships with others

Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10

5. CURRENT TREATMENTS

Please tick any medications or treatments you are currently using or have used in the past for pain.

- ☐ Tylenol (acetaminophen)
- ☐ NSAIDs (e.g. ibuprofen, naproxen, Advil, Aleve)
- ☐ Gabapentin (Neurontin)
- ☐ Pregabalin (Lyrica)
- ☐ Duloxetine (Cymbalta)
- ☐ Venlafaxine (Effexor)
- ☐ Opioid (e.g. codeine, morphine, oxycodone, hydromorphone, fentanyl)
- ☐ Nabilone
- ☐ Injection (e.g. nerve block, cortisone shot)
- ☐ Other: _____

MEDICATION ALLERGIES OR SENSITIVITIES

Are you allergic or sensitive to any medications?

- ☐ No
- ☐ Yes, please list:
