Pain Management Questionnaire

Name: _____ **Date:** _____

Medical record number: _____

CURRENT MEDICATIONS:
LIST ALL the medications you take for chronic pain, anxiety, depression, muscle spasm, or sleep.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you had any of the following:

Yes	no		Yes	no	
		Blurred or double vision			Increase anxiety
		Daytime sleepiness			Increased depression
		Falling asleep during a conversation			Weight gain
		Dry mouth			Abdominal pain
		Nausea or vomiting			Constipation
		Unable to urinate			"Goose-flesh"
		Any other problems:			

CONSIDERING ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, rate how you are doing on the following scale. Place an X in the box below that best describes how you're doing on a scale of 0 to 100

VERY	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	**VERY**
WELL	**0**	**5**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**POORLY**

HOW MUCH PAIN HAD YOU HAD DURING THE PAST WEEK? Place an X in the box below that best describes your pain on a scale of 0 to 100.

Minimal Amount of pain:

NO	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	**SEVERE**
PAIN	**0**	**5**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**PAIN**

Maximal Amount of pain:

NO	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	**SEVERE**
PAIN	**0**	**5**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**PAIN**

Patient' Signature: _____