Southern Idaho Pain Institute

CLINTON L. DILLE M.D
BOARD CERTIFIED ANESTHESIOLOGIST

176 Falls Ave
Twin Falls ID 83301
Phone 208.733.3181
Fax 208.733.3168

PAIN QUESTIONNAIRE

Name _____ **Age** _____ **Date** _____

Referring Physician _____

Chief Complaint (problem you were referred for) _____

_____

Date of Injury _____

Brief History of Problem and description including onset of pain: _____

_____

_____

Circle the words that describe your pain:

constant	burning	stays in one place	coldness
intermittent	heavy	moves around	hotness
unpredictable	sharp	throbbing	annoying
only at night	tingling	pins/needles	
only during day	electrical shock	shooting	
day & night			

Is your pain worsened by any of the following? (Circle all that apply.)

standing	lying	sitting
bending	twisting	coughing

Activities that increase your pain: _____

_____

Activities that decrease your pain: _____

_____

Does pain keep you awake at night? YES NO

What time of day is pain the worst? _____

What activities have you quit doing because of your pain?

housework exercise work hobbies sports

Are you currently disabled because of your pain? YES NO

Are you currently involved in litigation? YES NO **Explain** _____

_____

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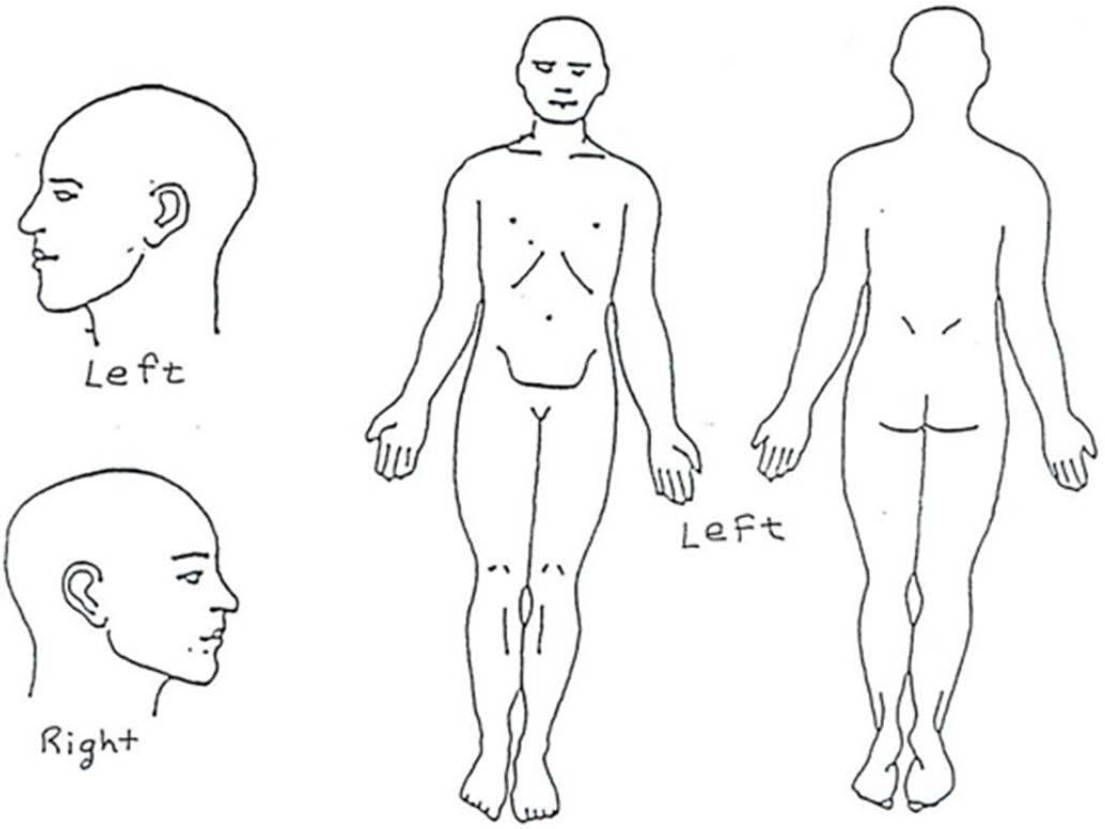
Please shade the figures where your pain starts and mark where it goes with an arrow.



Level of pain (circle one) 1 2 3 4 5 6 7 8 9 10 **(1 minimal to 10 max.)**

Which tests have you had done? (Give dates and locations)

MRI _____

CT Scan _____

X-Rays _____

Circle Treatments:

Physical Therapy	Chiropractor	Acupuncture
Surgery	Homeopath	TENS Unit
Hypnosis	Biofeedback	Psychologist/Psychiatrist

Medication List (current)

Non-Pain Medications	**Pain Medications**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

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Please list any known allergies with reaction you have: _____

_____

Past Medical History

Medical illnesses and date of onset:

1. _____
2. _____
3. _____
4. _____

Surgical History and date:

1. _____
2. _____
3. _____
4. _____

Are you currently taking anticoagulants/blood thinners/aspirin/persantine? (Circle if applies)

Do you have problems with bleeding/nosebleed? YES NO

Past Family Medical History

Please state if a family member has been diagnosed with an autoimmune disease. (Ex. Mother, Father, Children, Paternal/Maternal Grandmother/father, Sister, Brother, Aunt, Uncle (Blood relation ONLY))

Fibromyalgia: YES NO If so, WHO: _____

Lupus: YES NO If so, WHO: _____

Multiple Sclerosis: YES NO If so, WHO: _____

Rheumatoid Arthritis: YES NO If so, WHO: _____

Other Pain Conditions: YES NO If so, WHO: _____

Social History

Married Single Divorced Widowed Separated

Number of Children _____

Occupation _____

Hobbies _____

Do you smoke? YES NO How Much? _____

Do you drink? YES NO How Much? _____

Please review the list below and check all that are applicable. You may use the space to the right for any explanations.

( ) Severe Headaches _____

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( ) Paralysis of the face _____

( ) Emotional Problems _____

( ) Dizziness _____

( ) Chronic Sinus problems or nasal blockage _____

( ) Asthma or emphysema _____

( ) Chronic hoarseness _____

( ) Shortness of breath _____

( ) Blood in stool _____

( ) Blood in urine or trouble urinating _____

( ) Bleeding disorders _____

( ) Easy bruising or nosebleeds _____

( ) Menstrual disorder _____

( ) Complication after surgery _____

( ) Bad surgical result or unsatisfactory medical care _____

( ) Chest pain _____

( ) Heart disease _____

( ) High Blood Pressure _____

( ) Chronic Skin Condition _____

( ) Recurrent fever blisters _____

( ) Abnormal lump or node _____

( ) Unexplained weight loss _____

( ) Cancer _____

( ) Abdominal Pain _____

( ) Kidney or bladder problems _____

( ) Problems with bones or joints _____

( ) Broken bones _____

( ) Pregnancy (currently) _____

( ) Other _____

Signature of Patient _____ **Date** _____

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Date: ___/___/_____

Patient Name: _____

Patient DOB: ___/___/_____

Opiate Risk Assessment

		Mark each box that applies
1. Family History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
2. Personal History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
3. Age (Mark box if 16-45)		[ ]
4. History of Preadolescent Sexual Abuse		[ ]
5. Psychological Disease	Attention Deficit Disorder	[ ]
	Obsessive Compulsive Disorder	[ ]
	Bipolar	[ ]
	Schizophrenia	[ ]
	Depression	[ ]

Patient Signature: _____